



**PINAL/GILA LONG TERM CARE
REQUEST FOR REFERRAL
WOUND CARE CENTERS/WOUND VAC
PLEASE FAX ALL REQUESTS TO (520) 866-6717**

MEMBER NAME: _____ MEMBER ID: _____

DOB: _____ OTHER INSURANCE: _____ MEDICARE A B

EPSDT eligible member? Yes NO CRS Eligible member? Yes No

REQUESTED PROVIDER: _____ ID: _____ PHONE: _____ FAX: _____

URGENCY STATUS (see * for definitions of status):

Standard (Based on members' condition – Not to exceed 14 days)

Expedited – Urgent (within 3 days)

Date of Service: _____ Appointment Time: _____

Service Requested: Wound VAC: Initial Continued Wound VAC
Wound Center: Initial Continued Treatment

Description (type of wound)	Length	Width	Depth	Necrosis	Tunneling	Undermining	Drainage	Location	Date of onset

Describe Tunneling, undermining drainage:

If necrosis present, what is plan for debridement?

History of past treatments used:

1.	
2.	
3.	
4.	

Is member willing to participate? Yes No

If wound is on an extremity, evaluate adequacy of Arterial status: _____

If wound is due to venous insufficiency has compression bandages/garments been consistently applied? Yes No

If NO explain: _____

Evaluate the Member's Nutritional Status: Excellent Good Fair Poor

If Fair or Poor, what is the treatment plan to improve status? _____

Section B: Complete for Subsequent Requests:

Progress Summary completed on:	**** ATTACH COPY ****
Progress towards goals:	
Expected outcome with further wound care/VAC intervention:	
# of units per treatment:	# of treatments per week:
Physician/Podiatrist to contact for questions/clarifications:	
Name: _____	Phone: _____ Fax: _____
Signature of requesting Party:	

***Standard Authorization Request:** This is a request that P/GLTC provides a decision as promptly as the member's health condition requires, but not later than 14 calendar days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to reach a decision.

Expedited Authorization Request: A request that P/GLTC provide a decision to the member as promptly as the enrollee's health condition requires, but not later than three working days following the receipt of the authorization request. If P/GLTC determines that additional information is needed to process a request and it would be in the member's best interest to pursue this information, P/GLTC will send out a Notice of Extension Letter (NOE) to the member. This letter notifies the member that more time is needed to process the request and that P/GLTC will not take longer than an additional 14 days to come to a decision.

Referral authorization is not guarantee of payment.