Post-Acute Prior Authorization Form

CLEAR FORM

Fax this form and all required documents to **855.662.7973.**

Required information
Please note that the following must accompany this form. Submission of incomplete information may result in processing delays.

1. **Face sheet if the patient recently had an acute stay or is currently in an acute stay**
2. **Medication list**
3. **Complete history and physical, including clinical updates or recent discharge summary**
4. **Physical therapy(PT)/occupational therapy (OT)/speech-language therapy (ST) information:**
   - Evaluations within ~48 hours prior to request date/time
   - Previous level of function
   - Current level of function
   - Current living situation
   - Discharge plan information

Patient/Provider Information	
Patient Name:	
Cigna ID Number:	**Date of Birth:**
Date of Service:	
Level of care: ☐ Skilled nursing facility/subacute rehabilitation ☐ Acute inpatient rehabilitation ☐ LTACH	
Primary diagnosis (ICD-10 code):	**Secondary diagnosis (ICD-10 code):**
Anticipated date of transfer to post-acute setting or start of care:	
Requesting provider	**Servicing provider**
Provider NPI Number:	**Provider NPI Number:**
Contact Name:	**Contact Name:**
Contact's Direct Telephone: ( ) **Direct Fax:** ( )	**Contact's Direct Telephone:** ( ) **Direct Fax:** ( )
For a list of contracted providers, visit Medicareproviders.cigna.com > Online Provider Directory	

Reason for out-of-network referral *(if applicable):*

If facility is out of network, are they willing to accept 100% Medicare allowable rate: ☐ Yes ☐ No

Skilled need(s):**

IV antibiotics: Medication Name: _____ Dosage: _____
Start Date: _____ Stop Date: _____ Frequency: _____

Other IV therapies required: Medication Name: _____ Dosage: _____
Start Date: _____ Stop Date: _____ Frequency: _____

IV access: ☐ Peripheral ☐ PICC ☐ Central

Complete wound care needs form if wounds are present. Wound vacuum in place: ☐ Yes ☐ No

Dialysis: ☐ Yes ☐ No | **Diabetic:** ☐ Yes ☐ No | **Sliding scale insulin information:** ☐ Yes ☐ No

Related to congestive heart failure, chronic obstructive pulmonary disease or other: ☐ Yes ☐ No

Supplemental oxygen needs: ☐ Yes ☐ No

PEG or G-tube with: _____ **Tube feeding is at goal rate:** ☐ Yes ☐ No

Treatment modalities to include: ☐ PT ☐ OT ☐ ST

Respiratory therapy required: ☐ Yes ☐ No **Isolation:** ☐ Yes ☐ No **Type:** _____

Ventilator setting *(if applicable):* _____

Additional Information:

_____

_____

_____

Peer-to-peer consultation information is required for inpatient rehabilitation, long-term acute care hospital (LTACH) and retroactive requests.* Please provide the telephone number of a hospital medical doctor (MD), doctor of osteopathic medicine (DO), physician assistant (PA), or nurse practitioner (NP) and the days/times they are available to conduct a peer-to-peer consultation. Note that we require this information up front to avoid delays in processing time. Providers do have the right to decline a peer-to-peer consultation

Contact Name: _____

Contact phone: (____) _____

Peer-to-peer declined: ☐ Yes ☐ No

Form completed by: _____

Direct Telephone: (____) _____ **Direct Fax:** (____) _____

*Peer-to-peer consultation information may also be requested in cases where skilled nurse facility requests do not meet medical necessity criteria.
**Skilled needs include wound care, IV antibiotics, and other skilled procedures such as nursing needs or tube feeding. Please provide specifics.

To initiate a post-acute stay request via telephone or to check on the status of an existing request, contact our post-acute queue line at **888.200.1037**, Monday - Friday, 8 a.m. - 5 p.m. CST.

Note: If you are calling to initiate a request, you must still complete and fax the Post-Acute Prior Authorization Form.

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Wound Care Needs Form

CLEAR FORM

If wounds are present, please fax this form with the Post-Acute Prior Authorization Form to **855.662.7973.**

Date: _____

Patient/Provider Information	
Patient Name:	
Cigna ID Number:	**Date of Birth:**

Wound Description/Specifications	
Type of wound:	
Location:	
Stage:	
Measurements:	
Drainage *(type/odor/amount)*:	
Slough:	
Type of dressing:	
Frequency of dressing change:	

Type of wound:	
Location:	
Stage:	
Measurements:	
Drainage *(type/odor/amount)*:	
Slough:	
Type of dressing:	
Frequency of dressing change:	

Type of wound:	
Location:	
Stage:	
Measurements:	
Drainage *(type/odor/amount)*:	
Slough:	
Type of dressing:	
Frequency of dressing change:	

Please copy this form if you have additional wound care notes.

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