Recuperative Care Prior Authorization Request

Is member interested in a voluntary recuperative care stay? ☐ Yes ☐ No **(Please stop and do not continue)**

Please complete form and attach required documents. After completion, you may submit the form via or secure email CMReferral@scanhealthplan.com. Incomplete forms and/or missing documents will delay decisions.

☐ Initial Referral
☐ Transfer Referral Request – ONLY to be used by Recuperative Care Site
☐ Retro Referral Request – ONLY to be used by Recuperative Care Site

Referral Source Information

External referral by* (select one): ☐ Clinic ☐ ECM ☐ Hospital ☐ PCP ☐ MG ☐ Recup ☐ Other:_____
Referring Individual Name:* _____
Referring Organization Name:* _____
Referrer Phone Number:* ( ) _____
Referrer Fax Number:* ( ) _____

Member Information

Member Name:* _____
Member's Medi-Cal Client ID #* (CIN):* _____ Member Date of Birth:* _____
Member Address if known:* _____
Member Primary Phone Number:* ( ) _____ Best Time to Contact:* _____
Member's Preferred Language:* _____
Gender:* ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Non-Binary ☐ Other_____

Homeless Status HUD*

☐ Chronically Homeless ☐ Homeless

Current Living Location:*

☐ Street ☐ Shelter ☐ Homeless ☐ Interim Housing ☐ LTC ☐ Recuperative Care ☐ Other _____

Hospital/SNF Admission Information*

Date of admission: _____/_____/_____ Reason for Admission: _____
Member's current hospital/SNF location, if applicable: _____
Diagnoses: _____
Mental Health History: _____
Height: _____ Weight: _____ Allergies: _____
Communicable disease: ☐ Yes ☐ No **If YES, please include documentation**
Colonized: ☐ Yes ☐ No **If YES, please include documentation**

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DIAGNOSIS*: Please answer ALL questions.

ADLs

1. Can Member Self Represent? ☐ Yes ☐ No
2. Is Member Independent w/ADLs? ☐ Yes ☐ No
   If NO, please explain _____
3. Self-administer all medication? ☐ Yes ☐ No
   If NO, please explain _____
4. Continent with bladder? ☐ Yes ☐ No
   If NO, can self-care be completed independently?
   ☐ Yes ☐ No
5. Continent with bowel? ☐ Yes ☐ No
   If NO, can self-care be completed independently?
   ☐ Yes ☐ No
6. Colostomy Care? ☐ Yes ☐ No
   If YES, who is providing colostomy supply?
   _____
7. Catheter Care? ☐ Yes ☐ No
   If YES, can it be done independently?
   ☐ Yes ☐ No
8. Can member perform wound care independently?
   ☐ Yes ☐ No
   If NO, please arrange with Home Health.

DME Dependent

1. Walker ☐ Yes ☐ No
2. Cane ☐ Yes ☐ No
3. Crutches ☐ Yes ☐ No
4. Wheel Chair ☐ Yes ☐ No
   Please check one of the following:
   ☐ Manual Wheel Chair
   ☐ Electrical Wheel Chair
5. Oxygen ☐ Yes ☐ No
   Please indicate how many liters' member will be discharged with_____
6. Wound Vac ☐ Yes ☐ No
7. Bipap ☐ Yes ☐ No
8. CiPap ☐ Yes ☐ No
9. Other _____

Substance Use

Alcohol ☐ Yes ☐ No
Cocaine ☐ Yes ☐ No
Heroin ☐ Yes ☐ No
Methamphetamines ☐ Yes ☐ No
Methadone Clinic needed? ☐ Yes ☐ No
Other _____

Additional Clinical Information

IV Antibiotics
☐ Yes ☐ No **If YES, please attach documentation**

Medical/Medication Management & Education
☐ Yes ☐ No

Wound Care ☐ Yes ☐ No

Physical Therapy ☐ Yes ☐ No

Home Health: Must be arranged prior to discharge to recuperative care site*

Check here if the member does not have Home Health orders at this time. ☐

Name of Home Health Provider: _____

Phone #: ( )_____ Confirmation start of services _____/_____/_____

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Follow up appointments*

Prior to hospital discharge, please arrange all follow up appointments required. Walk-in appointments **WILL NOT** be accepted and referral will not move forward. Please list the following:

Provider Name	Phone Number	Appointment Date/Time	Appointment Reason	Address

Please attach Documents: All documents required upon submission*

☐ Face Sheet ☐ CXR or PPD (within last year) ☐ History & Physical
☐ S.W. Notes ☐ Consultation Notes (if applicable) ☐ Recent PT/OT/ Speech Therapy (if applicable)
☐ Medication List ☐ Wound Care Notes (if any) ☐ COVID-19 Test Required
☐ Psych Notes (if applicable) – Please include the last two days of nursing documentation
☐ ONLY for *Recuperative Care Transfers* – (Please include hospital clinical documentation and recup site progress notes)

Request to Transfer into an SCAN Bed

ONLY for newly enrolled SCAN members currently in Recuperative Care

Name of Referred Hospital: _____
Initial Admission Date: _____ /_____ /_____
Days Authorized by Hospital: _____
Scheduled Exit on Initial Referral: _____ /_____ /_____
Requesting Start of Services: _____ /_____ /_____
Justification for Continued Stay: _____
_____
_____
_____
_____