P.O. Box 11045 Orange, CA 92856
Fax No. 714-246-8843

Phone No. 714-246-8600

Long-Term Care Authorization Request Form (Admissions)

☐ Initial ☐ Reauthorization ☐ Retroactive Eligibility
☐ Bed Hold/Leave of Absence ☐ Retro-authorization

SECTION I

Date of Admission: _____ **Dates of Service Requested From:** _____ **To:** _____

PROVIDER: Authorization does not guarantee payment. CalOptima Health ELIGIBILITY must be verified at the time services are rendered.

Patient Name: _____ ☐ M ☐ F **D.O.B.** _____ **Age:** _____
Last First

Mailing Address: _____ **City:** _____ **ZIP:** _____ **Phone:** _____

CIN: _____ **Aid Code:** _____ **County Code:** _____

Facility Name:	**Physician Name:**
Facility Address: **City:** **ZIP:** **Phone:**	**Physician Address:** **City:** **ZIP:** **Phone:**
Fax #:	**Fax #:**
Medi-Cal Provider ID #/NPI:	**Physician Medi-Cal ID #:**
Former Facility:	**ICD-10 Code:**
Office Contact:	**Physician Signature:**

☐ SNF ☐ ICF ☐ ICFDD ☐ ICFDDN ☐ ICFDDH ☐ SUBACUTE-VENT ☐ SUBACUTE-NON-VENT

SECTION II Admitted From:

- ☐ Member's home
- ☐ Household of another
- ☐ Board and Care (B&C)/assisted living
- ☐ Acute hospital — Home/B&C immediately prior to acute
- ☐ Acute hospital — SNF/ICF immediately prior to acute
- ☐ Another SNF/ICF

SECTION III

Date PASRR completed: _____

PASRR Level I Results: ☐ **Negative** ☐ **Positive** ☐ **30-day exempt**

PASRR CID: _____

If Level I PASRR is positive, submit Level II Evaluation and Determination Letter

SECTION IV Patient's General Condition:

- ☐ Bedridden
- ☐ Ambulatory with assistance
- ☐ Ambulatory
- ☐ Incontinent of bladder and bowel
- ☐ Confined to wheelchair.
- ☐ Maximum assist with all ADLs

SECTION V

Community placement alternatives considered? ☐ YES ☐ NO

If no, select all applicable boxes

- ☐ Community resources unavailable
- ☐ Due to, or change in medical, mental and physical functioning.
- ☐ Caregiver unavailable
- ☐ Resident, conservator or family choice
- ☐ Other