Post-Acute Facility Continued Stay Review Form

For Family Care Partnership Program Members ONLY

For Family Care (LTC) members call 1-866-937-2783 and ask to speak to the member's Interdisciplinary Team Staff (IDTS) about authorization requirements. CCI UM does not review or authorize any services for the LTC program.

Please complete this form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, phone: 262-207-9393, please call UM with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	DOB:	Medicare #: Medicaid #:
Provider Name/Clinic:		
Tax ID:	NPI #:	
Clinical Review:	Phone Number:	Fax Number:
Contact/Title:		
DATE OF REVIEW:		

Skilled Nursing Services: Frequency:_____ Detailed, current notes regarding the services: -Ventilator Settings and RT notes -Wound Care Notes (Dimension, Treatment Orders -IV Antibiotic Information (Dose, Frequency, Stop Date)	Update Enter Here:

Physical Therapy: Frequency:					
Transfers:	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
Ambulation:_____ (feet using device)_____	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
Gait (describe):			Balance (describe):		
Stairs: ☐Yes ☐NO_____ # of stairs					

Privacy and confidentiality: The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 262-207-9393 (phone) or 414-384-8272 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation

Post-Acute Facility Continued Stay Review Form

For Family Care Partnership Program Members ONLY

For Family Care (LTC) members call 1-866-937-2783 and ask to speak to the member's Interdisciplinary Team Staff (IDTS) about authorization requirements. CCI UM does not review or authorize any services for the LTC program.

Occupational Therapy: Frequency: _____					
ADL's Upper Body	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
ADL's Lower Body	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
Toileting:	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
Bed Mobility:	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____

Speech Therapy:	
Frequency:	Diet:
Progress:	

SNF Medicare A Discharge Plan:	
Projected SNF MED A discharge/LCD date:	Barriers to discharge:
Weekly Update/Progress towards established plan of care goals:	

Privacy and confidentiality: The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 262-207-9393 (phone) or 414-384-8272 (fax) and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation