Long Term Care Services
Phone: (855) 427-1223
Fax: (213) 438-4877

Long Term Care Authorization Request Form

LTC Authorization Request:

☐ SNF ☐ Sub-Acute (Vent) ☐ Sub-Acute (Non-Vent)

☐ Initial ☐ Re-Authorization ☐ Retroactive Eligibility

☐ Bed Hold/Leave of Absence
Bed Hold Start Date: ______________________

SECTION I

PROVIDER: Authorization Does Not Guarantee Payment. L.A. Care Eligibility Must Be Verified At the Time the Services Are Rendered.

Patient Name: _____________________ **Gender :** ☐ **Male** ☐ **Female** **D.O.B:** ____________ **Age:** _____

Mailing Address: ___________________________________ **City:** _______________________ **Zip:** ___________

Phone #: _______________________

CIN: ______________________ **Aid Code:** ________________ **County Code:** _______________

Primary Insurance: ___________________ **Secondary Insurance:**________________________ **Medicare Status:** _________

☐ **Benefits NOT Exhausted** **Number of Medicare Days Available:** __________________ ☐ **L.A. Care D-SNP**
☐ **Benefits Exhausted** **Date Medicare Benefits Exhausted:** ___________________ ☐ **D-SNP Other**

Facility Name: _____________________________ **Physician Name:** _____________________________
Facility Address: ____________________________ **Physician Phone #:** _____________________________
Facility Fax: ________________________________ **Physician Fax#:** ______________________________
Facility Contact: _____________________________

Diagnosis/Diagnoses: ________________________________ **ICD – 9 Code/s:**_____________________________________

SECTION II
Admitted From:
☐ Home
☐ Board & Care
☐ Acute Hospital
☐ Emergency Room
☐ SNF

SECTION III
Date of LTC Placement Referral: ________________

Community Options Available: ☐ Yes ☐ No

Type of Options: ______________________________________

Reason for LTC SNF Placement: __________________________

SECTION IV
Patient's General Condition:
☐ Confined To Bed
☐ Ambulatory ☐ Ambulatory with Assistance
☐ Wheelchair Confined
☐ Incontinent of Bowel and Bladder
☐ Maximum Assist with all ADLs
☐ Other ___________________________________

SECTION V
Referring Person Name: _______________________
Phone Number: ______________________________

Additional Comments:
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