INSTRUCTION FOR FORM PCF03: REQUEST FOR REHAB EXTENSION

NOTE: Fields 1 – 5 MUST be filled in and you must attach a completed P.C. F01.

Any incomplete form WILL BE REJECTED

1. Enter the assigned Pre-Certification Case Number.

2. Enter the 13-digit recipient Medicaid identification number.

3. Enter the recipient's last name, first name, and middle initial.

4. Enter the seven-digit hospital Medicaid number.

5. Enter the extension ICD-9-CM diagnosis code. **An extension diagnosis code is required. Also, the description of the diagnosis is required.**

6. If this is a reconsideration request, check this box.

7. Enter the appropriate outpatient surgical procedure codes, if applicable.

8. Enter the anticipated or actual date of surgery (if applicable).

9. Indicate the number of physician evaluations performed per 24 hours.

10 – 25. Use these fields to complete pertinent medical information regarding the recipient. If additional information is necessary, up to two pages may be submitted.

26. **An authorized signature is required. Requests will not be accepted if not signed.**

27. Enter the date this request is submitted to Molina.

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Rehab Extension

Please Print or Type

PRE-CERT CASE # (1)

RECIPIENT ID NUMBER (2)	RECIPIENT LAST NAME (3) FIRST MI	PROVIDER NUMBER (4)

ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION (5)	CHECK HERE IF THIS REQUEST IS FOR A RECONSIDERATION (6) ☐	SURGICAL PROCEDURE ICD-9 (Hospital) (7) 1 2 3	SURGERY DATE (8) ___/___/___

SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION

1) **Physician evaluations** (9) _____ times per 24 hours.

2) **Last multidisciplinary staffing date** (10) _____

3) **Past medical history** (Pertinent to extension diagnosis):

(11)

4) **Physical exam findings** (Pertinent to extension diagnosis):

(12)

5) **Vital signs** (List frequency. If febrile, list date and time. If cultures done, list date and result):

(13)

6) **IV** (List type and rate. Include ALL IV fluids and T.P.N.). Include type of access (peripheral, central):

(14)

7) **Medications** (List with dosage, route, and frequency, especially those relating to extension diagnosis):

(15)

8) **Labs, X-Rays, and Procedures** (List those pertinent to extension diagnosis):

(16)

9) **Decubitus ulcers?** Yes _____ No _____ If yes, list #, stage, and location. List applicable treatment(s) (dsqs, whirlpool, hyperbarics, etc.)

(17)

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Rehab Extension

PRE-CERT CASE #

10) **Wounds** other than decubitus ulcers? Yes _____ No _____ If Yes, list number, stage (if applicable), and location. List treatment(s) performed.

(18)

11) **Pulmonary:** Is patient on ventilator? Yes _____ No _____

Is patient weanable? Yes _____ No _____ If yes, tell how this is being accomplished. If no, explain why.

(19)

Respiratory treatments? Yes _____ No _____ If yes, list time and frequency.

12) **Nutritional Status:** A) Mode of nutrition: _____TPN, _____NGT, _____GT/JT, or _____Oral.

(20) B) Diet type: _____

13) **Physical Therapy** (Please summarize):

(21)

14) **Occupational Therapy** (Please summarize):

(22)

15) **Speech Therapy** (Please summarize):

(23)

16) **Summary of medical necessity for hospitalization:**

(24)

17) **Discharge planning** and/or estimated discharge date:

(25)

PROVIDER SIGNATURE: (26) _____ **DATE OF REQUEST:** (27) _____

Up to two additional pages may be attached if necessary.

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Rehab Extension

Please Print or Type

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ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION	CHECK HERE IF THIS REQUEST IS FOR A RECONSIDERATION ☐	**SURGICAL PROCEDURE** ICD-9 (Hospital) 1 2 3	**SURGERY DATE** ____/____/____

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16) **Summary of medical necessity for hospitalization:**

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PROVIDER SIGNATURE: _____ **DATE :** _____

Up to two additional pages may be attached if necessary.