STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
NEONATAL/NEWBORN LEVEL OF CARE REQUEST
Please Print or Type

Date: _____
Time: _____

PRE-CERT CASE #

RECIPIENT ID NUMBER | RECIPIENT LAST NAME FIRST MI | PROVIDER NUMBER

ICD-9-CM diagnosis code with description to maximum specificity.

1 ☐☐☐.☐☐ _____
2 ☐☐☐.☐☐ _____
3 ☐☐☐.☐☐ _____
4 ☐☐☐.☐☐ _____

REQUEST TYPE

- Initial ☐
- Extension ☐
- Resubmittal ☐
- Reconsideration ☐
- Update ☐

LEVEL OF CARE

General
- Newborn Nursery Level 1 ☐
- Special Care Nursery Level II ☐
- Transitional Care Nursery ☐

Neonatal ICU Nursery Level III ☐

MEDICAL HISTORY AND MATERNAL CONDITIONS
The medical information submitted shall be from written documentation in the patient's medical record.

CLINICAL AND PHYSICAL EXAM FINDINGS (severity of illness)
Date and time _____ Birth weight in grams: _____ Current weight in grams: _____ Corrected gestational age: _____

Trend of weight gain per week _____

Other _____

Vital Signs: ☐ <hourly ☐ Hourly ☐ Every 2 hours ☐ Every 4 hours ☐ List Abnormal _____

CARE ENVIRONMENT: ☐ Radiant Warmer ☐ Isolette ☐ Open Crib

OXYGEN:_____liters via ☐ Nasal Cannula ☐ Ventilator ☐ CPAP ☐ Jet Vent ☐ Oxyhood _____ % oxygen

MONITORING:

Apnea/bradycardia episodes (# in 24 hours) ☐ Numerous (>10) ☐ Occasional (3-10) ☐ Infrequent (<3) ☐ None

Cardiorespiratory ☐ Continuous ☐ Apnea monitoring ☐ No monitoring

CLINICAL FINDINGS:
Vital Signs, Labs, X-rays, imaging studies, EKG, Invasive procedures (those pertinent to diagnosis): _____

_____

TREATMENT (intensity of services):

Cardio/Respiratory ☐ Pulse Ox ☐ IPPB ☐ Nebulizer ☐ ECMO ☐ OTHER

Intravenous: Fluids/TPN (List ALL types)_____

_____

Oral Feedings: ☐ Continuous OG ☐ OG every _____ hours ☐ Nippling _____ times per day

Surgical Procedure(s): ICD-9-CM hospital procedure code & description: _____ _____ _____ Date: _____

Phototherapy (# of lights): Start/stop dates: _____

MEDICATIONS (Specify route, frequency, etc.) Start dates and discontinued dates. _____

_____

_____

_____

DATE/STATUS OF DISCHARGE PLAN: _____

_____

Hospital Contact Person: _____ Phone: _____ Fax: _____

I declare the foregoing recipient's medical information is true and correct.

Provider Reviewer Signature _____ Title: _____ Date: _____