INSTRUCTIONS FOR FORM PCF06:
LONG TERM EXTENSION OR RECONSIDERATION

NOTE:
Fields 1 – 5 and field 8 MUST be filled in and you must attach a complete P.C.F01.

Any incomplete form WILL BE REJECTED.

1. Enter the assigned Pre-Certification Case Number if this is an extension or reconsideration. If this is an initial request for hospitalization for an outpatient procedure, leave this field blank.

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 admitting and primary (if applicable) ICD-9-CM diagnoses codes if this is an initial request. If this is an extension request, enter the extension ICD-9-CM diagnosis code. **Either an admitting or an extension diagnosis code is required. Also, the description of the diagnosis is required.**

6. Enter the appropriate outpatient surgical procedure codes. The hospital should enter the appropriate ICD-9-CM surgical procedure codes.

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

8. Check in the appropriate box the type of request: hospital extension or reconsideration.

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	SURGICAL PROCEDURE ICD-9 (Hospital)	SURGERY DATE	REQUEST TYPE
(5)	1 (6) 2 3	(7) ___/___/___	EXTENSION ☐ RECONSIDERATION ☐ (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:** (27) _____

Up to two additional pages may be attached if necessary.

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Long Term Extension/Reconsideration

Please Print or Type

PRE-CERT CASE #

RECIPIENT ID NUMBER	RECIPIENT LAST NAME FIRST MI	PROVIDER NUMBER

ICD-9-CM EXTENSION DIAGNOSIS AND DESCRIPTION	SURGICAL PROCEDURE ICD-9 (Hospital)	SURGERY DATE	REQUEST TYPE
	1 2 3	____/____/____	EXTENSION ☐ RECONSIDERATION ☐

SUGGESTED GUIDELINES FOR MEDICAL DOCUMENTATION

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

2) **Last multidisciplinary staffing date** _____

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

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

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

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

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

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

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

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.

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.

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

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

B) Diet type: _____

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

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

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

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

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

PROVIDER SIGNATURE: _____ **DATE:** _____

Up to two additional pages may be attached if necessary.