

Inpatient Rehabilitation and Long Term Acute Care Hospital

Submit completed form via fax to 1-833-263-4869 or email PriorAuth@MediGold.com.

Patient Information

Patient First Name	Last Name	Middle Initial
Member ID	Date of Birth	Phone Number
Estimated Admission Date	Dx Code	

Facility Information

Rehab/LTACH	Ordering Physician
NPI Number	TIN Number
Person Submitting Form	Contact Person (if different)
Phone Number	Fax Number

Skilled Services (Mark all that apply and send all supporting documentation):

- | | | |
|---|--|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Tube feeding |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Telemetry | <input type="checkbox"/> Hemodialysis |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> IV Medication | <input type="checkbox"/> Other (Describe below) |
| <input type="checkbox"/> Wound care | <input type="checkbox"/> Ventilator | |

Prior Level of Function

Expected Discharge Disposition

Please note: Any approval set forth on this form is not a guarantee of payment by the Plan.

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