

# Inpatient Rehabilitation and Long Term Acute Care Hospital

Submit completed form via fax to 1-833-263-4869 or email [PriorAuth@MediGold.com](mailto: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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