blue california
Promise Health Plan

# Custodial Long-Term Care (LTC) Treatment Authorization Request

Dear Provider,

Thank you for contacting Blue Shield of California Promise Health Plan (Blue Shield Promise). Below is the custodial long-term care Treatment Authorization Request (TAR) form. Please use this form when requesting prior authorization for custodial care.

The following information is required, along with the below TAR form, when requesting an approval for custodial care.

- Face Sheet
- Delegation of Parental Authority (DOPA), if any
- Minimum data set (MDS)
- State TAR
- Preadmission Screening and Resident Review (PASRR)
- List of mediations
- Medi-Cal long term care facility admission and discharge notification (MC 171)
- Current Interdisciplinary Team (IDT) meeting
- List of current specialists treating member
- Date of last PCP visit and last progress notes
- Current Health & Physical (H&P)
- Certification for Special Treatment Program Services form HS231, if requesting intermediate care facility/developmentally disabled (ICF/DD)

If you have questions or need assistance with this form, please contact the Long-Term Care Department via phone at (855) 622-2755, Monday through Friday, 8 a.m. to 9 a.m., or by fax at (844) 200-0121.

Sincerely,

Blue Shield Promise
Long-Term Care Department

# Custodial Long-Term Care (LTC) Treatment Authorization Request Form

Initial Reauthorization Bed Hold / LOA Discharge Notice

| **Section 1.** | | |
|---|---|---|
| Patient last name: | Patient first name: | |
| Gender: ☐ Male ☐ Female | Date of birth: | Age: |
| Patient identification number: | Client identification number (CIN): | |
| Mailing address: | City: | ZIP code: |
| Patient phone: | Diagnosis: | |
| Medicare eligilble: ☐ Yes ☐ No | Date Medicare benefits exhausted: | |

| **General Condition** | | |
|---|---|---|
| ☐ Ambulatory | ☐ Ambulatory with assistance | ☐ Bedridden |
| ☐ Confined to wheelchair | ☐ Developmental Disability (DD) | |
| ☐ Incontinence of bladder and bowel (B&B) | ☐ Maximum assistance with all activities of daily living (ADL) | |

| Physician name: | National provider identifier: | |
|---|---|---|
| Office phone: | Office fax: | |
| Mailing address: | City: | ZIP code: |

| **Section 2.** | | |
|---|---|---|
| **Other Request:** | | |
| ☐ Home health | ☐ Medical supplies | ☐ Durable Medical Equipment (DME) |
| ☐ Skilled physical therapy (PT) / occupational therapy (OT) / speech therapy (ST) | | |

| **Facility request type:** | | |
|---|---|---|
| ☐ Sub-Acute (vent) | ☐ Sub-Acute (non-vent) | ☐ Intermediate care facility (ICF) |
| ☐ ICF/Developmentally Disabled (DD) | ☐ ICF/DD-Habilitative | ☐ ICF/DD-Nursing |
| ☐ Skilled nursing facility (SNF) | | |

| Facility name: | Facility contact name: | |
|---|---|---|
| Facility phone: | Facility fax: | |
| Mailing address: | City: | ZIP code: |

| **Admitted from:** | | | | |
|---|---|---|---|---|
| ☐ Home | ☐ Board & Care/Assisted living facility | ☐ Another SNF | ☐ Acute hospital | ☐ Homeless |

| Section 3. | |
|---|---|
| Please attach <u>current</u> Health & Physical and supporting medical records for review | |
| Request date: | Time of request: |
| Additional comments: | |
| This section is to be completed by Blue Shield Promise UM Department <u>only</u> | |
| Active Medi-Cal Eligibility? ☐ Yes ☐ No | Assigned to Blue Shield Promise? ☐ Yes ☐ No |
| Reviewer: | Date: |

**Fax the completed form to Blue Shield Promise long term care department at (844) 200-0121.**