Blue Shield of California Promise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755

Re: Custodial Long-Term Care (LTC) – Authorization Request Form

Hello,

Thank you for contacting Blue Shield of California Promise Health Plan. Attached is the Custodial Care Long Term Care Treatment Authorization Request (TAR) form. Please use this form when requesting prior authorization for Custodial Care.

Along with the TAR form, the following information is required when requesting an approval:

- Face sheet
- DOPA (if any)
- MDS
- State TAR
- PASARR
- List of Medication
- MC 171
- Current IDT Meeting
- List of Current Specialists Treating Member
- Date of Last PCP Visit/ Last Progress Notes
- H&P

If you have any questions or need further assistance, please contact the Long-Term Care department at (855) 622-2755 or fax (844) 200-0121.

Sincerely,

MLTSS-LTC Department

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association.

blue california
Promise Health Plan

Blue Shield of CaliforniaPromise Health Plan
601 Potrero Grande Drive, Monterey Park, CA 91755
3131 Camino Del Rio North, Ste 1300, San Diego, CA 92108

MLTSS/ Long-Term Care Phone: (855) 622-2755
MLTSS/ Long-Term Care Fax: (844) 200-0121

Custodial Long Term Care (LTC) – Authorization Request Form

☐ Initial ☐ Reauthorization ☐ Bed Hold/ LOA ☐ Discharge Notice

Section I

Patient Name: ______________________ ☐M ☐F DOB: ____________ Age: _____
Mailing Address: ______________________ City: ____________ Zip: _________
Phone: ______________ ID # ______________ CIN # ______________

Medicare Eligible? ☐ Yes ☐ No Date Medicare Benefits Exhausted: ______________
Diagnosis: ____

General Condition: ☐ Bedridden ☐ Ambulatory with Assistance ☐ Ambulatory ☐ Confined to Wheelchair ☐ Maximum Assistance with all ADLs ☐ Incontinent of B&B

Physician Name: ______________________ NPI: ______________
Office Number: ______________________ Office Fax: ______________
Mailing Address: ______________________ City: ____________ Zip: _________

Section II

Facility Request Type: ☐ SNF ☐ Sub-Acute *(Vent)* ☐ Sub-Acute *(Non-Vent)*
Facility Name: ______________________ Contact Person: ______________
Telephone #: ______________________ Fax: ______________
Address: ______________________ City: ____________ Zip: _________

Admitted from: ☐Home ☐Board & Care/ALF ☐Acute Hospital ☐Another SNF ☐Homeless

Section III

Please attach current Health & Physical and supporting medical records for review.

Request Date: ______________________ Time of Request: ______________
Additional Comments: ____

To be completed by Blue Shield of California Promise Health Plan UM Department ONLY:

Active Medi-Cal Eligibility? ☐ Yes ☐ No Assigned to Blue Shield Promise? ☐ Yes ☐ No

Reviewer ______________________ Date: ______________

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