Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Inpatient Rehabilitation

Upload this request through the Provider Web Portal. For questions regarding this form, call: (800) 525-2395

DATE OF REQUEST: _____ /_____ /_____

REQUEST TYPE: ☐ Admission ☐ Continued Stay ☐ Retrospective Review ☐ Unscheduled Revision

REQUIRED FOR RETROSPECTIVE REVIEWS ONLY
This recipient was determined eligible for Medicaid benefits on: _____ /_____ /_____

NOTES:

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient ID:	DOB:	Phone:
Address:		
City:	State:	Zip Code:
Guardian Name (if applicable):		Guardian Phone:
Medicare Insurance Information: ☐ Part A ☐ Part B Medicare ID#:		
Other Insurance Name:	Other Insurance ID#:	

ORDERING PROVIDER INFORMATION

Ordering Provider Name:		
NPI:		
Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name:		

SERVICING / RECEIVING PROVIDER INFORMATION

Rehabilitation Facility Name:		
NPI:		
Facility Address:		
City:	State:	Zip Code:
Phone:	Fax:	
Contact Name:		

CLINICAL INFORMATION

Is this request for Healthy Kids (EPSDT) referral/services? ☐ Yes ☐ No

Check the box next to each deficit that applies: ☐ ADLs ☐ Ambulation ☐ Bowel ☐ Bladder ☐ Communication ☐ Cognitive ☐ Mobility ☐ Weight Bearing Restrictions

Ventilator: ☐ Yes ☐ No	Is a pressure ulcer present? ☐ No ☐ Yes: Location: _____
FIMS: _____	Stage: _____ Measurements: _____
Rancho Los Amigos Scale *(for head injury)*:	Feeding Status:

Estimated Admittance Date: _____ Estimated Length of Stay: _____ days

Estimated Discharge Date: _____

Inpatient Rehabilitation

Rehabilitation Diagnosis Code	Description
1.	
2.	
3.	
Other Diagnosis Code	**Description**
1.	
2.	
3.	

Functional Deficits and Prognosis for Improvement:

Treatment Plan and Goals:

Discharge Plan, Destination and Available Support: