Molina Healthcare – Alternate Level of Care Request Form

Phone: 855-322-4077 Fax: 800-594-7404

Member Information	
Member Name:	**DOB:**
Member ID:	**Today's Date:**
Hospital Name:	**Hospital Admit Date:**
Facility Requested:	**Tentative Admit Date:**

Level of Care Requested:

☐ SNF/SAR ☐ Inpatient Rehabilitation ☐ LTAC

Hospital Contact Information:	CM/RN Name:	**Facility Contact Information:**	CM/RN Name:
	CM/RN Phone: **Confidential V/M?** ☐ Yes ☐ No		CM/RN Phone: **Confidential V/M?** ☐ Yes ☐ No
	CM/RN Fax:		CM/RN Fax:

Most Recent Vitals:		**Active Diagnosis (Include ICD-10 codes):**
BP:	**T:**	**1.**
P:	**Sp02:**	**2.**
	L RA / 02:	
R:		**3.**
Vent Settings:		**4.**
Current IV Meds:		**Pertinent Labs:**
End date:	**Frequency:**	
Restraints: ☐ Yes ☐ No		

Living Arrangements: ☐ Lives alone ☐ Lives with someone ☐ Homeless ☐ Other

Prior Level of Functioning before hospitalization: ☐ Independent ☐ Contact Guard ☐ Supervised ☐ W/C Bound ☐ DME ☐ Other

DOCUMENTS REQUIRED with this completed form for submission:

- Facesheet/Demographics
- H&P + Most recent attending MD progress notes
- OT & PT notes – no older than 48h from date of request
- PM&R note – no older than 48h from date of request (IPR only)
- Pt's prior level of function (DME used, level of assist needed and who assisted pt.)
- Pt's prior living arrangements
- LTAC: SPECIFIC documentation as to why pt. required LTAC level of care

****Therapy/Treatment notes within 3 days of discharge must be included with this request**