Long-Term Care (LTC) – Authorization Request Form (ARF)
(for LTC/Subacute/Hospice Room and Board)

The Alameda Alliance for Health (Alliance) Long-Term Care (LTC) Department Authorization Request Form (ARF) (*for LTC/Subacute/Hospice Room and Board)* is confidential. Filling out this form will help us better serve our members.

INSTRUCTIONS

1. Please print clearly, or type in all of the fields below.
2. Include the following attachments:
   a. Verification of Alliance eligibility
   b. Physician order with physician signature
   c. Documentation to support the level of care requested: (Minimum Data Set (MDS) 3.0, and notes related to discharge planning)
3. Please fax the completed form to the Alliance Long-Term Care (LTC) Department at **1.510.747.4191**.

For questions, please call the Alliance LTC Department at **1.510.747.4516**.

PLEASE NOTE: Incomplete forms may be delayed or declined and returned to the referral source. Authorization does not guarantee payment. The Alliance reserves the right to request additional documentation as needed to make a determination. Alliance eligibility must be verified at the time the services are rendered.

SECTION 1: MEMBER INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Language: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Alliance Member ID #: _____ Client Identification Number (CIN): _____

Aid Code: _____ County Code: _____

Primary Insurance: _____ Secondary Insurance: _____

SECTION 1: MEMBER INFORMATION (CONT.)

Medicare Status: _____

Benefit Status (please select only one (1)):

- ☐ Benefits exhausted:
  - Date Medicare Benefits Exhausted (MM/DD/YYYY): _____
  - Dual Eligible Special Needs Plan (D-SNP)
  - Please attach the Notice of Medicare Non-Coverage (NOMNC)
- ☐ Benefits **NOT** exhausted
  - Number of Medicare Days Available: _____
  - Other Dual Eligible Special Needs Plans (D-SNP)

SECTION 2: TYPE OF REQUEST

Please select only one (1):

- ☐ Routine
- ☐ Urgent (members being discharged from the hospital)
- ☐ Retro
- ☐ Modification Alliance Authorization #: _____

SECTION 3: AUTHORIZATION REQUEST

Please select only one (1):

- ☐ Initial
- ☐ Re-Authorization
- ☐ Retro-Active Eligibility
- ☐ Retro-Authorization

SECTION 4: LEVEL OF CARE REQUESTED

Requested Start Date: _____ Requested End Date: _____

Please select only one (1):

- ☐ Bed Hold (maximum of 7 days)
- ☐ Custodial Room and Board Day 0-30
- ☐ Custodial Room and Board Day >30
- ☐ Hospice Room and Board
- ☐ Leave of Absence (maximum of 18 days per calendar year)
- ☐ Pediatric Subacute Supplemental Rehabilitation Therapy Services
- ☐ Sub-Acute (Non-Vent) LOS Day 0-30
- ☐ Sub-Acute (Non-Vent) LOS Day >30
- ☐ Sub-Acute (Vent) LOS Day 0-30
- ☐ Sub-Acute (Vent) LOS Day >30

Member Last Name: _____ Member First Name: _____ CIN #: _____

SECTION 5: PROVIDER INFORMATION

Facility Name: _____

Facility Contact Last Name: _____ Facility Contact First Name: _____

Facility Address: _____

City: _____ State: _____ Zip Code: _____

Facility Phone Number: _____ Facility Fax Number: _____

Physician Last Name: _____ Physician First Name: _____

Physician Phone Number: _____ Physician Fax Number: _____

Diagnosis/Diagnoses: _____

ICD Codes: _____

SECTION 6: ADMISSION SOURCE/REFERRAL INFORMATION

Please select only one (1):

- ☐ Acute hospital
- ☐ Board & Care/Assisted Living
- ☐ Emergency room
- ☐ Home
- ☐ Transitioning from Skilled to Custodial Level of Care
- ☐ Other: _____

Date of LTC Placement Referral: _____ Community Options Available: ☐ Yes ☐ No

Reason for LTC SNF Placement: _____

SECTION 7: MEMBER'S GENERAL CONDITION

Please select all that apply:

- ☐ Ambulatory
- ☐ Ambulatory with assistance
- ☐ Confined to bed
- ☐ Incontinent of bowel and bladder
- ☐ Maximum assistance with all ADLs
- ☐ Wheelchair confined

SECTION 8: REFERRING PROVIDER INFORMATION

Last Name: _____ First Name: _____

Additional Comments:

_____

Member Last Name: _____ Member First Name: _____ CIN: _____