

Michigan Department of Health and Human Services  
**RECUPERATIVE CARE (RC) PRIOR AUTHORIZATION (PA) REQUEST DATA FORM**  
 Contact the Program Review Division Recuperative Care Phone Line: 844-732-8764.

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

This form must be retained in the beneficiary record.

1. Requesting RC Provider Name (Organization/Group)		2. Requesting RC Provider NPI	
3. RC Facility Street Address		City	State    ZIP Code
4. RC Provider Office Contact Information Name: _____ Phone Number: (    )    -    Email _____			
5. Beneficiary Name (Last, First, Middle Initial)		6. mihealth Card Number	7. Date of Birth /    /
8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Beneficiary Phone Number (    )    -	10. Beneficiary Homeless Management Information System Number	
11. Beneficiary is currently enrolled in: <input type="checkbox"/> Medicaid Fee-for-Service (FFS) only* <input type="checkbox"/> Medicaid Health Plan**			
12. Discharging Hospital Name: NPI:	13. Discharging Hospital Location (City)	14. Hospital Admission Date /    /	15. Hospital Discharge Date /    / <input type="checkbox"/> Anticipated <input type="checkbox"/> Confirmed
16. RC Facility Admission Date    /    / <input type="checkbox"/> Anticipated <input type="checkbox"/> Confirmed		17. RC Facility Anticipated Discharge Date    /    /	
<b>18. Beneficiary is homeless as defined by Housing and Urban Development, homeless category 1, literally homeless (§ 578.3).</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning the individual: <input type="checkbox"/> Has a primary nighttime residence that is a public or private place not meant for human habitation; or <input type="checkbox"/> Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or <input type="checkbox"/> Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.			
<b>19. Based on medical record documentation including, but not limited to,:</b> Most recent history and physical examination, hospital consultation reports, emergency department notes (if applicable), most recent updated plan of care (POC) signed and dated by the ordering/managing physician, most recent signed and dated nursing assessment including a summary of the beneficiary's current status compared to their baseline status and completed by a registered nurse, hospital discharge plan (completed within 2 days of this PA request) including anticipated discharge orders for services such as medical follow-up, durable medical equipment/supplies, and medications, this beneficiary is: <ul style="list-style-type: none"> <li>• Discharging from an inpatient hospital admission for an acute condition that can be addressed in less than 90 days. <span style="float: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</span></li> </ul>			

- Medically stable upon discharge from inpatient hospital stay.  Yes  No
- At risk for re-hospitalization or severe complications without the support of recuperative care services.  Yes  No
- NOT eligible for continued hospital admission, nursing facility, inpatient behavioral health, inpatient psychiatric, or other inpatient services.  Yes  No

20. **Based on Physical Therapy and/or Occupational Therapy assessment** conducted during current hospitalization, including a summary of the beneficiary's current functional status or level of functional independence with ADLs, DME and medication management, this beneficiary is:

- Independently mobile.  Yes  No
- Able to complete ADLs (such as transfers, bed mobility, eating, toileting, etc.) without physical assistance, cueing, or supervision.  Yes  No
- Able to manage any medications independently.  Yes  No
- Able to manage any durable medical equipment/supplies independently.  Yes  No

21. **Based on Social Work notes/assessment**, other consultations, and medical record documentation conducted during current hospitalization:

- Beneficiary has a need for case management and supportive services.  Yes  No

22. **FFS Prior Authorization is required for all Medicaid beneficiaries.**

- \*Medicaid FFS-only beneficiary requires PA for: **G9002 Care Coordination** and **S9976 Room & Board**
- \*\*Medicaid Health Plan enrollee requires PA for: **S9976 Room & Board** (Care Coordination is covered by the MHP.)

23. **PA Determination: Contacted the Program Review Division Recuperative Care Phone Line on / / with the following result:**

- Approval issued. Authorization # \_\_\_\_\_  Unable to issue a determination at this time due to incomplete information. Tracking # \_\_\_\_\_
- Denial issued. Tracking # \_\_\_\_\_  Beneficiary not eligible. Tracking # \_\_\_\_\_

24. **PROVIDER CERTIFICATION:** The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.

Provider's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

AUTHORITY: Title XIX of the Social Security Act  
 COMPLETION: Is voluntary, but is required if payment from applicable program is sought.

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