

Request for Prior Authorization of Skilled Nursing Services



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|--|--|-------------------------------------|--|--------------------|--|
| 1. Requested Service Start Date: | | 2. Waiver Care Plan Dates: From: | | 3. Waiver Program: | |
| Request Type: <input type="checkbox"/> New <input type="checkbox"/> Renewal <input type="checkbox"/> Modification | | To: | | | |
| 4. Participant Information: WY Medicaid ID: Name: Address: Date of Birth: Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | | | 5. Service Provider Information: WY Medicaid Provider ID: Name: Address: Telephone Number: Registered Nurse Completing Form: | | |
| 6. Medications Dose/Frequency/Route/New Changed: | | | | | |
| 7. Principal Diagnosis: | | ICD-10: | | Date: | |
| 8. Other Pertinent Diagnoses: | | ICD-10: | | Date: | |
| 9. DME and Supplies: | | | 10. Safety Measures: | | |
| 11. Nutritional Requirements: | | | 12. Allergies: | | |
| 13A. Functional Limitations: <input type="checkbox"/> Amputation <input type="checkbox"/> Paralysis <input type="checkbox"/> Legally Blind <input type="checkbox"/> Bowel/Bladder <input type="checkbox"/> Endurance <input type="checkbox"/> Dyspnea With <input type="checkbox"/> Contracture <input type="checkbox"/> Ambulation <input type="checkbox"/> Minimal Exertion <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Other (Specify): | | | 13B. Activities Permitted: <input type="checkbox"/> Complete Bedrest <input type="checkbox"/> Partial Weight <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedrest BRP <input type="checkbox"/> Bearing <input type="checkbox"/> Walker <input type="checkbox"/> Up As Tolerated <input type="checkbox"/> Independent <input type="checkbox"/> No Restrictions <input type="checkbox"/> Transfer Bed/Chair <input type="checkbox"/> At Home <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Exercises Prescribed <input type="checkbox"/> Crutches <input type="checkbox"/> Cane | | |
| 14. Mental Status: <input type="checkbox"/> Oriented <input type="checkbox"/> Depressed <input type="checkbox"/> Agitated <input type="checkbox"/> Comatose <input type="checkbox"/> Disoriented <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Forgetful <input type="checkbox"/> Lethargic | | | 15. Prognosis: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Excellent <input type="checkbox"/> Guarded <input type="checkbox"/> Good | | |
| 16. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration): | | | | | |
| 17. Goals/Rehabilitation/Potential Discharge Plans: | | | | | |
| 18. Residential Service Coordination: <input type="checkbox"/> Yes (Specify) <input type="checkbox"/> No | | | | | |
| 19. Registered Nurse Signature and Date: | | | 20. I have assessed this participant and attest to the information provided in this request as a true and accurate representation of the participant's current condition and need for skilled nursing services. | | |
| 21. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal/State funds may be subject to fine, imprisonment, or civil penalty under applicable Federal/State laws. | | | | | |