

*Extraordinary Recipients: MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.*

|                                |                                 |                                   |                                     |
|--------------------------------|---------------------------------|-----------------------------------|-------------------------------------|
| <b>Required Documentation:</b> | 1) PASRR & Date                 | 4) History & Physical (<1 yr old) | 7) Progress notes                   |
|                                | 2) LT 101 less than 45 days old | 5) Drug history                   | 8) Itemized cost                    |
|                                | 3) MDS assessment               | 6) Nursing Care Plan              | 9) MD statement w/Dx & expected LOS |
| <b>Ventilator Dependent?</b>   | Y / N                           |                                   |                                     |

**Note: Preadmission certification DOES NOT guarantee payment or client eligibility**

Date requested \_\_\_\_\_  
 Admission date \_\_\_\_\_  
 Hospital \_\_\_\_\_  
 Hospital EqualityCare ID # \_\_\_\_\_  
 Hospital UR rep \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 Fax # \_\_\_\_\_

| For APS Healthcare Use Only |                          |
|-----------------------------|--------------------------|
| Date received               | _____                    |
| Approved                    | _____ Approved YTD _____ |
| Denied                      | _____                    |
| Certified Through           | _____                    |
| Reviewed By                 | _____                    |
| Auth #                      | _____                    |

**The facility has agreed to share the status of the authorization with the member.**

Attending/referring physician (first and last name) \_\_\_\_\_  
 Physician Wyoming EqualityCare ID # \_\_\_\_\_ Phone # \_\_\_\_\_  
 Address \_\_\_\_\_

**PATIENT INFORMATION**

Name \_\_\_\_\_ EqualityCare ID # \_\_\_\_\_  
 Address \_\_\_\_\_ Phone # \_\_\_\_\_  
 DOB \_\_\_\_\_ SS# \_\_\_\_\_ Sex: Male Female

**ICD-9-CM code(s) (provide ALL code numbers as well as diagnosis names)**

|          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**HCPCS code(s) (provide ALL code numbers as well as diagnosis names)**

|          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**Fax form to APS Healthcare toll-free @ 1- 888- 245-1928**

**Forms can be found on-line at [www.wyoming.apshealthcare.com](http://www.wyoming.apshealthcare.com)**