blue california
Promise Health Plan

# Custodial Long-Term Care (LTC) Treatment Authorization Request

Dear Provider,

Thank you for contacting Blue Shield of California Promise Health Plan (Blue Shield Promise). Below is the custodial long-term care Treatment Authorization Request (TAR) form. Please use this form when requesting prior authorization for custodial care.

The following information is **required**, along with the TAR form below, when requesting approval for custodial care.

**Please use the checklist to ensure that you have included all required information.**

| | |
|---|---|
| ☐ | Face Sheet |
| ☐ | Durable Power of Attorney (DPOA) and/or Delegation of Parental Authority (DOPA), if any |
| ☐ | Medi-Cal long-term care facility admission and discharge notification (MC 171) |
| ☐ | Minimum data set (MDS) |
| ☐ | State TAR |
| ☐ | Preadmission Screening and Resident Review (PASRR) |
| ☐ | List of medications |
| ☐ | Current Interdisciplinary Team (IDT) meeting |
| ☐ | List of current specialists treating member |
| ☐ | Date of last primary care physician (PCP) visit and last progress notes |
| ☐ | Current Health & Physical (H&P) |
| ☐ | Certification for Special Treatment Program Services form HS231, if requesting intermediate care facility/developmentally disabled (ICF/DD) |

If you have questions or need assistance with this form, please contact the Long-term Care Department via phone at (855) 622-2755, between 8 a.m. and 5 p.m. PT, Monday through Friday, or by fax at (844) 200-0121.

Sincerely,

Blue Shield Promise
Long-Term Care Department

# Custodial Long-term Care (LTC) Treatment Authorization Request Form

☐ Initial ☐ Reauthorization ☐ Bed Hold / LOA ☐ Discharge Notice

| **Section 1** | | | |
|---|---|---|---|
| Patient last name: | Patient first name: | | |
| Gender: ☐ Male ☐ Female ☐ Non-binary | Date of birth: | | Age: |
| Patient identification number: | Client identification number (CIN): | | |
| Mailing address: | City: | State: | ZIP code: |
| Patient phone: | Diagnosis: | | |
| Eligible for Medicare: ☐ Yes ☐ No | Date Medicare benefits exhausted: | | |

| **General Condition** | | |
|---|---|---|
| ☐ Ambulatory | ☐ Ambulatory with assistance | ☐ Bedridden |
| ☐ Confined to wheelchair | ☐ Developmental Disability (DD) | |
| ☐ Incontinence of bladder and bowel (B&B) | ☐ Maximum assistance with all activities of daily living (ADL) | |

| Physician name: | | | |
|---|---|---|---|
| Tax identification number (TIN): | National provider identifier (NPI): | | |
| Office phone: | Office fax: | | |
| Mailing address: | City: | State: | ZIP code: |

| **Section 2** | | |
|---|---|---|
| **Other Request:** | | |
| ☐ Home health | ☐ Medical supplies | ☐ Durable medical equipment (DME) |
| ☐ Skilled physical therapy (PT) / occupational therapy (OT) / speech therapy (ST) | | |

| **Facility request type:** | | |
|---|---|---|
| ☐ Sub-acute (vent) | ☐ Sub-acute (non-vent) | ☐ Intermediate care facility (ICF) |
| ☐ ICF/Developmentally Disabled (DD) | ☐ ICF/DD-Habilitative | ☐ ICF/DD-Nursing |
| ☐ Skilled nursing facility (SNF) | ☐ Assisted living facility/Congregate living facility | |

| Facility name: | Facility contact name: | | |
|---|---|---|---|
| Tax identification number (TIN): | National provider identifier (NPI): | | |
| Facility phone: | Facility fax: | | |
| Mailing address: | City: | State: | ZIP code: |

| **Admitted from:** | | | | |
|---|---|---|---|---|
| ☐ Home | ☐ Board & Care/Assisted living facility | ☐ Another SNF | ☐ Acute hospital | ☐ Homeless |

| Section 3 | |
|---|---|
| **Please attach the patient's current Health & Physical form and supporting medical records for review.** | |
| Request date: | Time of request: |
| Additional comments: | |

| The section below is to be completed only by the Blue Shield Promise Utilization Management Department | |
|---|---|
| Active Medi-Cal eligibility? ☐ Yes ☐ No | Assigned to Blue Shield Promise? ☐ Yes ☐ No |
| Reviewer: | Date: |

**Please fax the completed form to Blue Shield Promise Long-term Care Department at (844) 200-0121.**