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 of California Promise Health Plan
Long-Term Care Department

blueshieldca.com/promise

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)
☐ 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 the Blue Shield Promise Long-term Care Department at (844) 200-0121.