Recuperative Care Authorization Request Form

Clear Form

Provider: Use this form to request ongoing recuperative care for a MHCP member that will exceed a 21-day stay within the calendar year. Extended stays are not expected to go past 60 days.
This includes:

- When a member requires recuperative care services for more than 21 days and any readmission to recuperative care services for the same or new diagnosis.

Complete all sections of this form. Incomplete, illegible or inaccurate forms will be returned to sender. Please allow up to 14 calendar days for your request to be completed.

Fax form and any relevant medication information to 612-884-2033

For questions, call Provider Assistance Center at: 612-676-3300

Email: mhsudservices@ucare.org

Type of Admission:		
☐ Extension greater than 21 days	☐ Readmission (new diagnosis)	☐ Retro Request

MEMBER INFORMATION

First Name _____ Last Name _____

Member ID _____ Date of Birth _____

ICD-10 code _____ Date of Admission _____

FACILITY INFORMATION

Facility Name _____

Street Address _____ City _____ State _____ Zip Code _____

Provider NPI/UMPI _____ Contact Name _____

Phone Number _____ Fax Number _____ Email Address _____

Criteria Needed for Type of Admission

Specify the MHCP member's continued needs by writing your initials next to all that apply.

_____ Wound Care _____ Medication Management _____ Continued Care Coordination

_____ Activities of Daily Living _____ Other (specify): _____

Reason for extension

MEMBER ACKNOWLEDGEMENT

By affixing my signature below, I have made a decision to extend my stay for ongoing recuperative care beyond the 21-day stay or request for a readmission to the facility listed above. I was informed of the extended stay or readmission process and all of the information above is accurate to the best of my knowledge. I agree that UCare may use and release information regarding my recuperative care: extended stay or readmission services to the facility provider above.

Member Signature _____ Signature Date _____

Member Phone Number _____

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that use my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes, 325L.02(h), 325L.05 and 325L.08)

Authorized Officer Name (Type or Print Name) _____ Title _____

Authorized Officer Signature _____ Signature Date _____