Molina Healthcare of Washington
SNF Bariatric Care Request Form
Phone Number: (800) 869-7175
Fax Number: (800) 767-7188

Attn: ____________________________

For questions about this program, please call phone number above and request to speak with Post-Acute Supervisor.

MEMBER INFORMATION

Plan:	☐ Medicaid		
Member Name:		DOB:	/ /
Member ID#:		Phone:	( ) -
Service Type:	☐ Elective/Routine	☐ Expedited/Urgent	

This request pertains to higher level of care needs for a bariatric member being considered for admission. Please complete this form to help Molina understand the extensive care and therapy needs of the bariatric member leaving the hospital.

SERVICE TYPE REQUESTED

In order to process requests in a timely manner, please include the following:

- Accepting Facility (unable to process requests without facility)
- Admissions Notes—History & Physical
- Detailed, current notes regarding the services requested:
  - PT/OT/ST Evaluations and Progress Notes
  - Ventilator Setting and RT Notes
  - Wound Care Notes (Dimensions, Treatment Orders)
  - IV Antibiotic Information (Dose, Frequency, Stop Date)

Bariatric Equipment Needs:	Does your facility currently have the following available? • Beds ☐ Yes ☐ No ☐ Must Purchase/Lease • Bariatric Ceiling Lift ☐ Yes ☐ No ☐ Must Purchase/Lease • Commode ☐ Yes ☐ No ☐ Must Purchase/Lease • Wheelchairs ☐ Yes ☐ No ☐ Must Purchase/Lease • Bariatric Lift ☐ Yes ☐ No ☐ Must Purchase/Lease • Rooms able to accommodate bariatric equipment needs ☐ Yes ☐ No • Other: ____________________
Level of Assistance Needed (Describe Weight and Mobility Needs):	
Length of Stay Anticipated for Therapy Needs Due to Bariatric Status:	☐ 14 days ☐ 21 days ☐ 28 days ☐ Other _________________
Other Needs Adding to Complexity e.g., Wounds:	
Daily Rate Requested with Justification:	
Diagnosis Code & Description:	
CPT/HCPC Code & Description:	
Date(s) of Service Requested:	From / / To / /

Please send clinical notes and any supporting documentation at the time of the request.

PROVIDER INFORMATION

Requesting Facility Name:		NPI#:		TIN#:	
Requesting Facility Phone Number:		Fax Number:		TIN#:	
Requesting Facility Name:		NPI#:		TIN#:	
Requesting Facility Phone Number:		Fax Number:		TIN#:	
Contact at Requesting Provider's office:					