

**CONTINUED STAY FORM  
PHYSICAL REHABILITATION**  
For Wyoming EqualityCare

**Note: 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	_____ Denied _____
Certified Through	_____
Reviewed By	_____
PCN#	_____

**PATIENT INFORMATION**

Name \_\_\_\_\_ EqualityCare ID # \_\_\_\_\_

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

1. \_\_\_\_\_ 3. \_\_\_\_\_  
 2. \_\_\_\_\_ 4. \_\_\_\_\_

***Please attach current multi-disciplinary team notes.***

1. Patient continues to receive three (3) hours of therapy per day five (5) days a week? Y / N
2. Patient continues to receive two (2) therapy modalities per day? Y / N

List therapies \_\_\_\_\_

3. Members progress (PT, OT, ST notes, new goals) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Treatment plan reviewed and/or revised every week? Y / N

5. Anticipated discharge date and needs \_\_\_\_\_  
 \_\_\_\_\_

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