

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#	_____

You have one working day from date of admission to notify APS Healthcare of admission and for a PCN# to be issued.

Attending/referring physician (first and last name) _____
 Physician Wyoming EqualityCare ID # _____ Phone # _____
 Address _____

PATIENT INFORMATION

Name _____ EqualityCare ID # _____
 Address _____ Phone # _____
 DOB _____ SS# _____ Sex: Male Female

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

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

Please attach current multi-disciplinary team notes.

1. Rehabilitation consult completed? Y / N Please enclose copy.
2. Reason for rehabilitation/type of injury (date) _____
3. Rehabilitation will help restore to his/her max function or independence? Y / N
4. Medically stable and able to endure active participation in at least three (3) hours of therapy per day five (5) days per week? Y / N
5. Ranchos Amigos scale of at least five (5)? Y / N List level _____
6. Will receive two (2) modalities of therapy 5-6 days per wk? Y / N
7. Requires close daily medical supervision by physicians, 24 hr. rehab nursing and/or other services? Y / N
8. Participate in interdisciplinary team meetings? Y / N Day of week and frequency _____
9. Include treatment plan based on measured goals and realistic expectations _____
10. Member will discharge home / skilled nursing facility / return to lower level of care? Y / N

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