1199SEIU Funds
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National Benefit Fund • Health Care Employees Pension Fund
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Care Management Programs
Cardiac/Pulmonary Rehabilitation for Authorization

Fax completed form with supporting clinical documentation to (646) 473-7447

Request Submitted By _____ **Request Date** _____ / _____ / _____

1199SEIU MEMBER INFORMATION

Member Name _____ _____
Last Name First Name

Member ID | | | | | | | | | | |

PATIENT INFORMATION (*If not the Member*)

Patient Name _____ _____
Last Name First Name

Date of Birth _____ / _____ / _____

TYPE OF SERVICE

☐ CARDIAC ☐ PULMONARY

CPT/HCPCS Code(s) & Description

Code _____

Description _____

_____

ICD 10 Code(s) & Description

PRINCIPAL _____

Description _____

_____

SECONDARY _____

Description _____

_____

Member ID

Patient Name

Last Name

First Name

Total # of rehabilitation visits rendered to date for current calendar year

How many visits pertaining to this current episode?

Start date of rehabilitation for this episode _____ / _____ / _____

Last date of rehabilitation for this episode _____ / _____ / _____

Total # of rehabilitation visits currently requesting

Reason for treatment:

Is this request relating to post-surgical care? ☐ No ☐ Yes

If yes, Type of Surgery _____ Date _____ / _____ / _____

Is the patient a smoker or have a history of smoking? ☐ No ☐ Yes If yes, How many pack(s) per day

Did the patient quit smoking? ☐ No ☐ Yes If Yes, Quit date _____ / _____ / _____

Date of evaluation _____ / _____ / _____

Date last seen by referring physician _____ / _____ / _____

Member ID | | | | | | | | | |

Patient Name

Last Name

First Name

CARDIAC ASSESSMENT

of Metabolic Equivalents achieved (METS) during exercise stress test

Risk Level ☐ HIGH ☐ INTERMEDIATE ☐ LOW

Exercise Tolerance / Level _____

Blood Pressure (BP) _____

PULMONARY ASSESSMENT

- ☐ FEV_1 less than 80% of predicted in patient with 1 or more hospital admissions
- ☐ FEV_1 less than 50% of predicted
- ☐ FEV_1/FVC less than 70%
- ☐ SaO_2 less than 90% at rest
- ☐ Acute exacerbation of chronic obstructive pulmonary disease
- ☐ Decreased ability to perform activities of daily living
- ☐ Increased dyspnea impeding patient's level of function

Active pulmonary infection ☐ No ☐ Yes

Pre or post operative for lung transplant or resection ☐ No ☐ Yes

Unstable cardiac disease ☐ No ☐ Yes

Unstable pulmonary hypertension ☐ No ☐ Yes

Overall Assessment of patient's condition:

Assessment of change in patient condition since last visit:

Management plan:

Member ID | | | | | | | | | |

Patient Name

Last Name

First Name

List quantifiable & attainable treatment goals:

Expected outcome:

PHYSICIAN INFORMATION

Physician Name

Date _____ / _____ / _____

Physician Specialty

Telephone (____) ____ - _____

Fax (____) ____ - _____

TIN (*Tax ID*)

Address

Street Name City State Zip Code

FACILITY/VENDOR INFORMATION *(Facility/Vendor providing the service)*

Facility/Vendor Name

TIN *(Tax ID)*

Telephone (____) ____ - _____

Fax (____) ____ - _____

Address

Street Name City State Zip Code

Member ID

Patient Name

Last Name

First Name

FACILITY/VENDOR INFORMATION *(Facility/Vendor providing the service)*

Vendor Authorized Signature _____

Name _____ **Title** _____

Please print clearly

Contact Person _____ **Title** _____

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

In order to process your request, the Provider TIN & Fax #'s along with the CPT/HCPS & ICD 10 codes must be included.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7447.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 5:00PM at (646) 473-7446.

Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.