1199SEIU Benefit Funds
498 Seventh Avenue, New York, NY 10018-0009 • Tel: (646) 473-7446 • Fax: (646) 473-7447 • www.1199SEIUBenefits.org • @1199SEIUBenefits

CARE MANAGEMENT PROGRAMS
CARDIAC/PULMONARY REHABILITATION FOR AUTHORIZATION

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

Please print clearly in blue or black ink, or complete online.

Request Submitted by: _____
FIRST NAME LAST NAME

Request Date: _____
(MM/DD/YYYY)

1199SEIU MEMBER INFORMATION

_____
MEMBER FULL NAME MEMBER ID #

PATIENT INFORMATION (IF NOT THE MEMBER)

_____
PATIENT FULL NAME DATE OF BIRTH

TYPE OF SERVICE: ☐ CARDIAC ☐ PULMONARY

HCPCS/CPT CODE(S) & DESCRIPTION

Code:_____

Description:_____

_____

ICD 10 CODE(S) & DESCRIPTION

PRINCIPAL:_____

Description:_____

_____

SECONDARY:_____

Description:_____

_____

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:_____

_____

MEMBER ID # PATIENT'S FULL NAME

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

If yes, type of surgery _____

Date _____
(MM/DD/YYYY)

Is the patient a smoker or have a history of smoking? ☐ Yes ☐ No

If yes, how many pack(s) per day: _____

Did the patient quit smoking? ☐ Yes ☐ No

If yes, quit date: _____
(MM/DD/YYYY)

Date of evaluation: _____
(MM/DD/YYYY)

Date last seen by referring physician: _____
(MM/DD/YYYY)

CARDIAC ASSESSMENT

# of Metabolic Equivalents achieved (METS) during exercise stress test

Risk Level ☐ HIGH ☐ INTERMEDIATE ☐ LOW

Exercise Tolerance/Level _____

Blood Pressure (BP) _____

PULMONARY ASSESSMENT

☐ FEV1 less than 80% of predicted in patient with 1 or more hospital admissions
☐ FEV1 less than 50% of predicted
☐ FEV1/FVC less than 70%
☐ SaO2 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 functioning

Active pulmonary infection ☐ Yes ☐ No
Pre- or post-operative for lung transplant or resection ☐ Yes ☐ No
Unstable cardiac disease ☐ Yes ☐ No
Unstable pulmonary hypertension ☐ Yes ☐ No

Overall assessment of patient's condition: _____

_____

Assessment of change in patient condition since last visit: _____

_____

MEMBER ID # PATIENT'S FULL NAME

Management plan: _____

List quantifiable and attainable treatment goals: _____

Expected outcome: _____

PHYSICIAN INFORMATION

PHYSICIAN FULL NAME DATE

PHYSICIAN SPECIALTY TELEPHONE # FAX # TIN # (TAX ID)

OFFICE ADDRESS CITY STATE ZIP CODE

FACILITY/VENDOR INFORMATION

NAME OF FACILITY/VENDOR PROVIDING TREATMENT TELEPHONE # FAX # TIN # (TAX ID)

OFFICE ADDRESS CITY STATE ZIP CODE

X _____

VENDOR AUTHORIZED SIGNATURE DATE (MM/DD/YYYY)

PRINT FULL NAME TITLE

CONTACT PERSON TITLE

TELEPHONE #

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 HCPCS/CPT & 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 5:00 pm 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.