Recuperative Care Program Request Form

Please complete all fields and fax to 503-416-4720.

Member and Provider Information

Member name: ____________________

ID#: ____________________ DOB: ____________________

Provider name: ____________________

Phone: ____________ Fax: ____________ Admit from: ____________

Member Information

Insurance (must be one of the below for coverage from CareOregon):

☐ HSO/CareOregon ☐ Jackson Care Connect ☐ Columbia Pacific CCO

Review and verify patient meets the following and medical records reflect (all are required for coverage):

☐ Member agrees to go to RCP and engage
☐ Member independent with ADLs
☐ Discharge anticipated within 2 business days
☐ Homeless
☐ No history of fire starting
☐ No current or recent suicidal ideation
☐ MH symptoms manageable in independent setting

Indicate what non-hospital care have been ordered for member:

☐ Wound care ☐ IV antibiotics ☐ Other (describe below)
☐ Physical therapy ☐ Occupational therapy

If other, describe: ____________________

Anticipated admit date to RCP: ____________________

FOR CAREOREGON ONLY

☐ **Approved** Authorization#: ____________________ Initial approval 30 days from admit date

☐ **Denied**

FOR RCP ONLY

Extension Request

Additional days requested (30 days max): ____________________

Reason for extension: ____________________

Contact name: ____________________ Contact phone: ____________________

☐ **Approved** Authorization#: ____________________ Initial approval 30 days from admit date

☐ **Denied**