OHSU Health Services

Recuperative Care Program (RCP) Request Form

Please complete all fields and email to ohsuhscareteam@ohsu.edu

Member and Provider Information

Member Name: _____ Date: _____

Member ID: _____ DOB: _____

Provider Name: _____

Provider Phone: _____ Provider Fax: _____ Admit From: _____

Referral Information

Insurance Coverage:

☐ HSO/OHSU Health Services

Request:

☐ Initial Request (30 days)

☐ Reauthorization Request, additional days requested (30 day max): _____

Reason for extension: _____

_____

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

☐ Physical therapy

☐ Occupational Therapy

☐ Other

If other, describe: _____

_____

Anticipated admit date to RCP: _____

FOR OHSU HEALTH SERVICES STAFF ONLY

☐ **Initial Request Approved (**Initial approval 30 days from admit date) **Authorization #:** _____

☐ **Reauthorization Request Approved** **Reauthorization #:** _____

☐ **Denied**

Contact Name: _____ Contact Phone: _____