FOR FASTER AUTHORIZATION,
PLEASE VISIT:
https://providers.carelonmedicalbenefitsmanagement.com/postacute/

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Initial Skilled Nursing Facility Authorization Request Form

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-623-3037
Questions? Call 877-291-0509

Date of Request:	☐ Standard ☐ Retro	☐ Urgent Request: *Note: Expedited organization determinations (urgent requests), can only be requested by the Member, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (see CMS regulation: 40.8)*

Member Information:

Member Name:	Member ID:	Date of Birth:

Requesting SNF Facility Information	*Referral Source Information*	
Facility Name:	Referral Source Type: ☐ Hospital ☐ SNF ☐ IRF ☐ LTACH ☐ Physician Office ☐ Emergency Dept ☐ Psychiatric Hosp/Unit	Ordering Physician: Ordering Physician NPI:
NPI: Tax ID:		Ordering Physician Tax ID:
Phone:	Referral Source:	Date of Onset of Illness/Injury/Exacerbation:
Fax:	Referral Source NPI:	Hospital admission date:
SNF Facility Contact Name:	Referral Source Contact Name:	Anticipated SNF Admit Date:
SNF Facility Contact Phone:	Referral Source Contact Phone:	Is member currently in your facility? ☐Y ☐N
SNF Facility Contact Fax:		

Submission MUST include the following as part of your referral package:
All pages of this referral form (fully completed – include comments)
Hospital H & P
Specialty consultations
Overall plan of care
Current medication list/record
Interdisciplinary Team Assessment (if completed)
3 days of most recent physician notes
1-2 days of most recent nursing notes
1-2 days of most recent wound care notes, if applicable
Therapist assessment/ current progress notes that provide relevant supplemental information (e.g., cognitive assessment scores, strength/motor recovery information) for PT/OT/ST
Most recent diagnostics (CT scans / X-ray reports) and lab work

Please attest to the following: (NOTE: All the following requirements must be met for request to meet medical necessity criteria)
☐ The patient is medically stable with medical or surgical comorbidities that do not require ongoing acute medical attention.
☐ The requested services are directly related to and reasonable in scope and intensity for the referral condition and/or illness.
☐ There is a reasonable expectation that the requested skilled care is necessary to achieve therapeutic goals.
☐ Improvement is expected in a reasonable and predictable time period.
☐ The patient's condition has reasonable potential to respond favorably to skilled therapies, medical, and/or nursing care.

Admitting ICD-10 Code(s)			
1(Primary)	2	3	4

Clinical Category – Choose 1			
☐ Acute Neurologic	☐ Wound	☐ Major Joint Replacementor Spinal Surgery	☐ Other
☐ Acute Infections	☐ Medical Management	☐ Orthopedic Surgery (Except - Major Joint or Spinal Surgery)	☐ Unknown
☐ Cardiovascular	☐ Cancer	☐ Non-Surgical Orthopedic/Musculoskeletal	☐ Pulmonary
	☐ Non-Orthopedic Surgery	☐ General weakness/deconditioning	

Please answer the following questions:
Can the needed services be reasonably and safely provided in the home or community? ☐ Yes ☐ No ☐ Unknown
Is there a caregiver identified and able to assist the patient at home? ☐ Yes ☐ No ☐ Unknown
Patient living situation: ☐ Home Alone ☐ Home with Spouse/Family ☐ Supportive Housing ☐ Long Term Care ☐ Homeless ☐ Other ☐ Unknown
Does the patient have a severe mental illness or developmental disability? ☐ Yes ☐ No ☐ Unknown
Does the patient have partial weight bearing or non-weight bearing restrictions? ☐ Yes ☐ No ☐ Unknown
Is the patient cooperative and able to follow 1- 2 step commands? ☐ Yes ☐ No ☐ Unknown

Documentation of member level of function ☐ Yes ☐ No ☐ Unknown	
Prior Level of Function?	Current Level of Function?
Select One	Select One
AM-PAC mobility score: ☐ 6-7 ☐ 8-15 ☐ 16-24 ☐ Unknown	

Select all the following skilled services the patient will require for post-acute care.	
Medical and/or nursing care	Anticipated Frequency: ☐ Daily ☐ Every other day ☐ Weekly ☐ Unknown
Physical therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown
Occupational therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown
Speech therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown
[IF nursing selected above] Does patient require daily skilled nursing for any of the following reasons?	
Wound Care	☐ Stage III or IV Decubitus Wound(s) ☐ Other wound(s) that require(s) multiple dressing changes within a 24-hour period
Ostomy Care	☐ Colostomy care during the early post-operative period (≤ 14 days from surgery) in the presence of complications is required.
Respiratory Care	☐ Naso-pharyngeal or deep tracheal suctioning ☐ Ventilator management and/or weaning ☐ Nebulizer treatments ≥ 2 times/day
IV/IM Medications	☐ IV medication ≥ 2 times/day that patient cannot self-administer. Patient does not have assistance at home, and cannot practically travel to an infusion center ☐ IM medication ≥ 2 times/day and patient cannot self-administer. ☐ Central line or multiple peripheral IV lines
Nutritional Support	☐ Initiation of tube feedings ≥ 500 ml daily or ≥ 26% of daily caloric intake is required. ☐ Initiation of intravenous (TPN) feeding requires skilled nursing care.
Genitourinary (GU)Care	☐ Initial clinical management of a urinary catheter (suprapubic or "in and out" catheterization) is required. ☐ Individual or caregiver requires complex teaching services that can only be delivered in a 24-hour SNF setting and cannot be completed at home.
Other	Describe:

Comment:

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