



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

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: <i>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)</i>
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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:
NPI:		Ordering Physician 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 Replacement or 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	

<i>Please answer the following questions:</i>			
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?	
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 (\leq 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 \geq 2 times/day				
IV/IM Medications	IV medication \geq 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 \geq 2 times/day and patient cannot self-administer. Central line or multiple peripheral IV lines				
Nutritional Support	Initiation of tube feedings \geq 500 ml daily or \geq 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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