



**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: 833-311-2986

Questions? Call 844-411-9622

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

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				
Patient living situation:	Alone at home	With spouse/partner at home	With family at home	Long-Term Care Facility
	Assisted Living Facility	Experiencing Homelessness	Other	Unknown
Is there a documented need for daily skilled care?	Yes	No	Unknown	
Is there a documented need for therapy services?	Yes	No	Unknown	

Documentation of member level of function	Yes	No	Unknown
Prior Level of Function?	Current Level of Function?		

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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