

**Skilled Nursing Facility Concurrent Request Form****PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986****Questions? Call 844-411-9622****FOR FASTER AUTHORIZATION,
PLEASE VISIT:**<https://providers.carelonmedicalbenefitsmanagement.com/postacute/>

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 Facility Information:		
Facility Name:		Facility Tax ID:
NPI:	Attending Physician:	Is there a medical power of attorney? ☐ Yes ☐ No ☐ Unknown
Phone:	Attending Physician NPI:	
Fax:		Name and relationship to patient:
SNF Facility Contact Name:	SNF admission date:	<i>If available, please attach POA/AOR with request</i>
SNF Facility Contact Phone:	Anticipated SNF Discharge date:	
SNF Facility Contact Fax:	Is member currently in your facility? ☐ Y ☐ N	
		Does the patient have an advanced directive? ☐ Yes ☐ No ☐ Unknown

Submission MUST include the following as part of your referral package:

- ☐ All pages of this referral form (fully completed – include comments).
- ☐ SNF H & P
- ☐ Specialty consultations
- ☐ Overall plan of care
- ☐ Admission Orders
- ☐ 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			
☐ 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	☐ General weakness/deconditioning	☐ Non-Orthopedic Surgery	

Reason For Continued Skilled Stay:

Other Medical Conditions:

Prior Level of Function Immediately Before Hospital Stay: Only fill in if not previously completed.

Ambulation: Select One	# Feet:								
Wheelchair Mobility: Select One									
Transfers: Grooming/Hygiene: Select One									
Bathing: Select One									
Dressing: Select One									
Previously used DME: <table border="0"> <tr> <td>☐ Wheelchair</td> <td>☐ Bedside Commode</td> </tr> <tr> <td>☐ Walker</td> <td>☐ Bath/Shower Chair</td> </tr> <tr> <td>☐ Brace</td> <td>☐ Unknown</td> </tr> <tr> <td>☐ Cane</td> <td>☐ Other(describe)</td> </tr> </table>		☐ Wheelchair	☐ Bedside Commode	☐ Walker	☐ Bath/Shower Chair	☐ Brace	☐ Unknown	☐ Cane	☐ Other(describe)
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Current Orders:

☐ Medical and/or nursing care	Frequency: ☐ Daily ☐ Every other day ☐ Weekly ☐ Unknown
☐ Physical therapy to address functional impairment	Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown
☐ Occupational therapy to address functional impairment	Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown
☐ Speech therapy to address functional impairment	Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown

Most recent vitals: Temp _____ Pulse _____ RR _____ BP _____ O2sat _____ Weight _____ Height _____
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Barriers to Discharge:	
If there are medical barriers to discharge, please document below:	
☐ Respiratory Care	☐ Naso-pharyngeal or deep tracheal suctioning ☐ Ventilator management and/or weaning. ☐ Nebulizer treatments $\geq$ 2 times/day ☐ Tracheotomy present

☐ 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 Type of line: _____ Insertion Date: _____ Medication: Name: _____ Dosage: _____ Frequency: _____ Estimated stop date: _____	
☐ Nutritional Support	Diet Type: Select One Other: _____ Route: ☐ NG ☐ PEG ☐ J Tube ☐ Dobhoff Insertion date: _____ Formula: _____ Amount/Rate: _____ ☐ Initiation of tube feedings ≥ 500 ml daily or $\geq 26\%$ of daily caloric intake is required. ☐ Initiation of intravenous (TPN) feeding requires skilled nursing care.	
☐ Ostomy Care	☐ Colostomy care during the early post-operative period (≤ 14 days from surgery) in the presence of complications requiring skilled nursing care.	
☐ Urinary	☐ 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..	
☐ Wound Care	☐ Multiple Stage II ☐ Stage III or IV Decubitus Wound(s) ☐ Other wound(s) that require(s) multiple dressing changes within a 24-hour period Location: _____ Date of Measurement: Size: LxWxD (cm) ____ x ____ x ____ Stage: Select One Description: _____ Wound Vac: ☐ Yes ☐ No Location: _____ Date of Measurement: Size: LxWxD (cm) ____ x ____ x ____ Stage: Select One Description: _____ Wound Vac: ☐ Yes ☐ No Location: _____ Date of Measurement: Size: LxWxD (cm) ____ x ____ x ____ Stage: Select One Description: _____ Wound Vac: ☐ Yes ☐ No	Location: _____ Date of Measurement: Size: LxWxD (cm) ____ x ____ x ____ Stage: Select One Description: _____ Wound Vac: ☐ Yes ☐ No Location: _____ Date of Measurement: Size: LxWxD (cm) ____ x ____ x ____ Stage: Select One Description: _____ Wound Vac: ☐ Yes ☐ No Location: _____ Date of Measurement: Size: LxWxD (cm) ____ x ____ x ____ Stage: Select One Description: _____ Wound Vac: ☐ Yes ☐ No

Dialysis: ☐ Yes ☐ No			☐ Acute ☐ Chronic ☐ HD ☐ Peritoneal Frequency: Access:										
Other:			Describe:										
Comments:													
If there are physical barriers to discharge, please document below:													
Date of Current Therapy Status: 													
Weight Bearing Status: Select One													
Ambulation: Select One		# of Feet: _____											
Wheelchair Mobility (if applicable): Select One													
Bed Mobility: Select One													
Transfers: Select One													
Stairs: Select One		# of Stairs: _____											
Feeding: Select One													
Grooming/Hygiene: Select One													
Bathing: Select One													
Dressing: Select One													
Toileting: Select One													
Additional DME required for discharge: <table style="width: 100%; margin-top: 10px;"> <tr> <td>☐ Wheelchair</td> <td>☐ Bedside Commode</td> </tr> <tr> <td>☐ Walker</td> <td>☐ Bath/Shower Chair</td> </tr> <tr> <td>☐ Cane</td> <td>☐ Unknown</td> </tr> <tr> <td>☐ Brace</td> <td>☐ Other (describe)</td> </tr> </table>						☐ Wheelchair	☐ Bedside Commode	☐ Walker	☐ Bath/Shower Chair	☐ Cane	☐ Unknown	☐ Brace	☐ Other (describe)
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If there are Cognitive/Mood/Speech barriers to discharge, please document below:													
Mental Status: Baseline _____ Current: Oriented X _____ :													
Level of consciousness: Select One													
Other: Select One													
Speech: Select One													
Comment:													
Care Conference Date/Discussion:													

Planned d/c living situation ☐ Home alone ☐ Home with spouse ☐ Home with Family/Caregivers ☐ Long Term Care ☐ Supportive housing ☐ Unknown

Discharge Planning (general):

Previous living situation

- ☐ Home alone ☐ Supportive Housing
☐ Home with spouse ☐ Homeless
☐ Home with family/caregiver ☐ Unknown
☐ Long Term Care ☐ Other (describe):

Planned d/c living situation

- ☐ Home alone ☐ Supportive Housing
☐ Home with spouse ☐ Unknown
☐ Home with family/caregivers ☐ Other(describe):
☐ Long Term Care

For discharge plans to return home:

Is there a caregiver identified and able to assist the patient?

Select One

[IF YES] Select One

[IF YES] Caregiver ability to provide care: Select One

[IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely? Select One

[IF YES] Has caregiver training been completed? Select One

Home Living Environment:

of steps to enter: _____ Rails: Select One

Is there a ramp to enter? Select One

Bed 1st Floor Select One

Bath 1st Floor Select One

Is there ability for first floor setup? Select One

If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? Select One

If yes, Name of Company:

For discharge plans to long term care or supportive housing:

Has a facility been chosen? Select One

[IF YES] Name of facility:

Has an application been completed? Select One

Is it anticipated that a bed/room be available for the patient? Select One

Is it anticipated that the facility will be able to provide the level of care needed at discharge? Select One

Does patient require an application for Medicaid? Select One

Discharge Plan Comment:

Additional Comment:

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