



Skilled Nursing Facility Continued Stay 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:	<input type="checkbox"/> Standard <input type="checkbox"/> 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)
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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:	
SNF Facility Contact Phone:	Anticipated SNF Discharge date:	<i>If available, please attach POA/AOR with request</i>
SNF Facility Contact Fax:	Is member currently in your facility? <input type="checkbox"/> Y <input type="checkbox"/> 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			
<input type="checkbox"/> Acute Neurologic	<input type="checkbox"/> Wound	<input type="checkbox"/> Major Joint Replacement or Spinal Surgery	<input type="checkbox"/> Other

Acute Infections	Medical Management	<input type="checkbox"/> Orthopedic Surgery (Except - Major Joint or Spinal Surgery)	Unknown
Cardiovascular	Cancer	Non-Surgical Orthopedic/Musculoskeletal	
Pulmonary	General weakness/deconditioning	<input type="checkbox"/> 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:	# Feet:								
Wheelchair Mobility:									
Transfers: Grooming/Hygiene:									
Bathing:									
Dressing:									
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:

<input type="checkbox"/> Medical and/or nursing care	Frequency:	Daily	Every other day	Weekly	Unknown
<input type="checkbox"/> Physical therapy to address functional impairment	Frequency:	1-2x/wk	3-4x/wk	5x/wk	Unknown
<input type="checkbox"/> Occupational therapy to address functional impairment	Frequency:	1-2x/wk	3-4x/wk	5x/wk	Unknown
<input type="checkbox"/> 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 ≥ 2 times/day Tracheotomy present

<input type="checkbox"/> IV/IM Medications	<p>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.</p> <p>IM medication \geq 2 times/day and patient cannot self-administer.</p> <p>Central line or multiple peripheral IV lines</p> <p>Type of line: _____ Insertion Date: _____</p> <p>Medication: Name: _____ Dosage: _____ Frequency: _____</p> <p>Estimated stop date: _____</p>	
<input type="checkbox"/> Nutritional Support	<p>Diet Type: _____ Other: _____</p> <p>Route: <input type="checkbox"/> NG <input type="checkbox"/> PEG <input type="checkbox"/> J Tube <input type="checkbox"/> Dobhoff</p> <p>Insertion date: _____</p> <p>Formula: _____ Amount/Rate: _____</p> <p><input type="checkbox"/> Initiation of tube feedings \geq 500 ml daily or \geq 26% of daily caloric intake is required.</p> <p><input type="checkbox"/> Initiation of intravenous (TPN) feeding requires skilled nursing care.</p>	
<input type="checkbox"/> Ostomy Care	<p>Colostomy care during the early post-operative period (\leq 14 days from surgery) in the presence of complications requiring skilled nursing care.</p>	
<input type="checkbox"/> Urinary	<p>Initial clinical management of a urinary catheter (suprapubic or "in and out" catheterization) is required.</p> <p>Individual or caregiver requires complex teaching services that can only be delivered in a 24-hour SNF setting and cannot be completed at home..</p>	
<p>Wound Care</p>	<p><input type="checkbox"/> Multiple Stage II</p> <p><input type="checkbox"/> Stage III or IV Decubitus Wound(s)</p> <p><input type="checkbox"/> Other wound(s) that require(s) multiple dressing changes within a 24-hour period</p> <p>Location: _____</p> <p>Date of Measurement: _____</p> <p>Size: LxWxD (cm) ____ x ____ x ____</p> <p>Stage: _____</p> <p>Description: _____</p> <p>Wound Vac: Yes No</p> <p>Location: _____</p> <p>Date of Measurement: _____</p> <p>Size: LxWxD (cm) ____ x ____ x ____</p> <p>Stage: _____</p> <p>Description: _____</p> <p>Wound Vac: Yes No</p>	<p>Location: _____</p> <p>Date of Measurement: _____</p> <p>Size: LxWxD (cm) ____ x ____ x ____</p> <p>Stage: _____</p> <p>Description: _____</p> <p>Wound Vac: Yes No</p> <p>Location: _____</p> <p>Date of Measurement: _____</p> <p>Size: LxWxD (cm) ____ x ____ x ____</p> <p>Stage: _____</p> <p>Description: _____</p> <p>Wound Vac: Yes No</p>

Discharge Planning (general):			
Previous living situation		Planned d/c living situation	
Home alone	Supportive Housing	Home alone	Supportive Housing
Home with spouse	Homeless	Home with spouse	Unknown
Home with family/caregiver	Unknown	Home with family/caregivers	Other(describe):
Long Term Care	Other (describe):	Long Term Care	
For discharge plans to return home:		For discharge plans to long term care or supportive housing:	
Is there a caregiver identified and able to assist the patient? [IF YES] [IF YES] Caregiver ability to provide care: [IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely? [IF YES] Has caregiver training been completed? Home Living Environment: # of steps to enter: _____ Rails: Is there a ramp to enter? Bed 1st Floor Bath 1st Floor Is there ability for first floor setup? n If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? If yes, Name of Company:		Has a facility been chosen? [IF YES] Name of facility: Has an application been completed? Is it anticipated that a bed/room be available for the patient? Is it anticipated that the facility will be able to provide the level of care needed at discharge? Does patient require an application for Medicaid? Discharge Plan Comment:	

Additional Comment:

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