



**SKILLED NURSING FACILITY
Concurrent Review Authorization Form**

For Concurrent Review Requests: Complete this form and fax to **800-575-4461**.
Please provide supporting clinical documentation where applicable.
Call **877-773-6964** to speak with a representative.

Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable. Pre-certifications and re-certifications are not a guarantee of payment. Incomplete submissions will be returned unprocessed.

Disclaimer Statements and Attestation			
• Verify eligibility and benefits prior to request. SNF benefits verified:	Yes	No	
• If "yes", number of days available: _____.			
• Is the admission a result of a motor-vehicle accident or workplace injury?	Yes	No	
• All therapy notes are within 24-48 hours of admission date (initial), or 72 hours prior to LCD (concurrent)?	Yes	No	
• SNF member is receiving at least one hour of therapy five days a week (only choose one answer):	Yes	No	
Sign and Date Here: _____			
Documents to Attach:	History & Physical Medication List	Discharge Summary (if available) Therapy notes, including level of participation (evaluation and last progress notes)	Clinical Progress Notes (for recertification requests)
Assessment Type/Coverage			
Facility Type:	Skilled Nursing Facility		SNF Admitting Diagnosis and ICD10 Code:
Member/Facility Information			
Member Name	Date of Birth	Member Address	
Member Policy Number	Member Phone Number	Admission Date	
Requesting Facility Name and NPI Number		Requesting Facility Address	
Requesting Facility Phone Number	Requesting Facility Fax Number	Requesting Facility Contact Name	
Servicing Facility Name and NPI Number		Servicing Facility Address	
Servicing Facility Phone Number	Servicing Facility Fax Number	Servicing Facility Contact Name	
Patient Information			
Primary Caregiver:	Child Spouse Friend Self Paid Caregiver	Contact Number:	
Residence Prior to Hospital Admission:	Lives alone Assisted living facility	Lives with family Long-term care/nursing home	Lives with paid caregiver Homeless Shelter
Advance Directive:	Yes No	DNR Status: Yes No	
Admission Information			
Admission Date to SNF		Hospital Admitting Diagnosis and ICD10 Code	
Admitting Physician (last name, first name, and NPI#)		Physician Address and Phone Number	
Significant Surgical History and Date(s)		Complications	
Medical History		Additional Notes/Comments	
SNF HIPPS Code:		Please indicate if there was a change in the initial HIPPS code: Yes No	
Has an IPA been submitted on this case? Yes No			
If YES, please provide clinical rationale:			
What PDPM clinical category does the member fall under?			
Major Joint Replacement or Spinal Surgery		Cancer	
Non-Surgical Orthopedic/Musculoskeletal		Pulmonary	
Orthopedic-Surgical Extremities Not Major Joint		Cardiovascular and Coagulation	
Acute Infections		Acute Neurologic	
Medical Management		Non-Orthopedic Surgery	

Mobility and Functional Status – Prior Level of Function (HOME)		
Ambulation (in feet): _____	Assist device used? Yes No	Type: _____
Ability to Perform ADLs (Section GG Items):	Dependent Max Assist Mod Assist Min Assist CGA SBA Independent	
Therapy Goals		
PT:		
OT:		
Mobility and Functional Status (CURRENT)		
Date of PT/OT Notes:	BIMS/CPS Score:	Weight Bearing Status:
Which of the following PT & OT clinical categories does the member fall under?		
Major Joint Replacement or Spinal Surgery	Non-Orthopedic Surgery & Acute Neurologic	
Other Orthopedic	Medical Management	
For the following areas, please use the # that correlates to the level of function of the patient:		
1. Dependent	6. Independent	
2. Substantial/Maximal Assistance	7. Resident Refused	
3. Partial/Moderate Assistance	8. Not Attempted	
4. Supervision or Touching Assistance	9. Not Applicable	
5. Set-up or Clean-up Assistance	10. Not attempted due to environmental conditions	
Eating:	Oral hygiene:	Toileting hygiene:
Sit to lying:	Lying to sitting on side of bed:	Sit to stand:
Chair to bed/bed to chair:	Toilet transfer:	Walk to 10 feet:
Walk 50 feet with 2 turns:	Walk 150 feet:	Stairs:
Speech		
Are they currently receiving SLP services?	Yes No	
SLP Related Co-morbid Conditions: (check all that apply)		
Apraxia	Dysphagia	ALS
Oral cancers	Speech and language deficits	Aphasia: CVA, TIA, or stroke
Hemiplegia or hemiparesis	TBI	Trach care
Ventilator or respirator	Laryngeal cancer	
Is there cognitive impairment?	Yes No	
Swallowing Disorder (check all that apply):	Yes No	
Loss of liquids/solids from mouth when eating or drinking	Holding food in mouth/cheeks or residual food in mouth after meals	
Coughing or choking during meals or when swallowing medications	Complaints of difficulty or pain with swallowing	
Non-Therapy Ancillary (NTA)		
Enter all that apply:		
Nursing		
Which skilled nursing care services are indicated? Clinical Characteristics: (check all that apply)		
SOB when lying flat	Trach, ventilator, isolation infection	Quadraplegia
Respiratory treatments, oxygen therapy	Radiation, Dialysis	Septicemia
Weight loss, vomiting, fever, dehydration	HIV/AIDS	IV meds
Indications of depression	Feeding tube	IV feedings
Behaviors	Parkinson's	Walking
Multiple pressure injuries/wounds	Pneumonia	Oral hygiene
Pain management	Bowel/Bladder incontinence	Surgical wound
Discharge Plans (must be initiated upon admission)		
Discharge Date (tentative):	Home Evaluation Date:	
DC Location: Home alone Home with family/support HHC/Company: _____ Assisted living Long-term care Adult foster care Other: _____	Equipment Needs:	
Discharge Barriers:	Supervision Needs:	