



SNF, LTAC & IRF Post-Acute Care Initial Precertification Form

INITIAL POST-ACUTE CARE REQUESTS: Fax to 844.216.0198 or call 866.220.3071 to speak with an eviCore representative.

Please provide supporting clinical documentation when applicable.

Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable. Preauthorization and authorization for continued stays are not a guarantee of payment.

Disclaimer statements and attestation			
• Verify eligibility and benefits prior to request. SNF/LTAC or IRF 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	
• Are all therapy notes within 24-48 hours of admission date?	Yes	No	
• SNF member is receiving at least one hour of therapy five days a week? (only choose one answer)	Yes	No	
• IRF member is receiving PT or OT at least three hours per day/five days per week and able to sit for one hour per day? (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 within the last 24-48 hours)	Clinical Progress Notes (for recertification requests)
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Assessment Type/Coverage

Facility Type Requesting:	SNF	IRF	LTAC	Estimated Length of Stay (# of days)
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Member/Facility Information

Member Name	Date of Birth	Member Address		
Policy Number	Member Phone Number		Hospital Admission Date	
Requesting Facility Name	Requesting Facility Address			
Requesting Facility Phone Number	Requesting Facility Fax number		Requesting Facility Reviewer Name	
Servicing Facility Name	Servicing Facility Address			
Servicing Facility Phone	Servicing Facility Contact Name (if known)		Servicing Facility NPI (if known)	

Member Information

Primary Caregiver	Contact Number	Child Paid caregiver	Spouse	Friend	Self
Residence Prior to Admission to Hospital:	Lives alone Assisted living facility	Lives with family Long term care/NH	Lives with paid caregiver	Homeless	Shelter

Admission Information

Expected Admission Date to PAC facility	Admitting Doctor	Admitting Doctor Address/Phone Number
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Along with this form, please submit the following (if applicable) with your precertification request. Any missing required information could result in an unnecessary delay or potential denial:

- Prior and current level of functioning
- PT/OT evaluation/progress notes within the last 24-48 hours
 - Ambulation: # of feet /Assist device used
 - Ability to perform ADL's
 - Bed Mobility
 - Transfers
 - Toileting transfers
 - Gait/Distance
- Number of steps at home/level of assistance needed
- Wound details: Wound size, location, treatments
- Complete Medication List
- SNF level requested (if applicable) _____