healthfirst
Health Insurance for New Yorkers

eviCore healthcare

INITIAL REQUESTS: PRIs and new SNF/Aute Rehab requests need to be submitted to Healthfirst's SNF fax line 1-212-601-6950 or Healthfirst's SNF secure email: PRIsubmit@healthfirst.org.
CONCURRENT REQUESTS: Fax to 1-855-826-3724. Call 1-877-773-6964 to speak with an eviCore representative. Please provide supporting clinical documentation when applicable.

SNF & IRF PAC Authorization Form

☐ Precertification
☐ Re-Sending
☐ Recertification

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

Disclaimer statements and attestation

- Verify eligibility and benefits prior to request. SNF 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
- All therapy notes are within 24–48 hours of admission date or last covered date (choose only one answer) ☐ Yes ☐ No
- SNF member is receiving at least one hour of therapy five days a week (choose only one answer) ☐Yes ☐ No
  - If no, is SNF stay for medical: IV therapy, vent , wound care, new PEG feeding, other? _____
- 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 (must submit documentation) ☐Yes ☐No

Sign and date here: _____

Documents to attach: History & Physical Discharge Summary (if available) Clinical Progress Notes (for recertification requests) Medication List Therapy notes, including level of participation (evaluation and last progress notes) PRI (dated within 7 days of request)

Assessment type/coverage

Facility type: ☐SNF ☐ IRF	**ELOS** (# of days)

Member/facility information

Member Name	Date of Birth	Address	
Policy Number	Member Phone Number	Requesting Provider Name	Admission Date
Requesting Provider Address	Requesting Provider Phone Number	Requesting Provider Fax Number	
Requesting Provider Reviewer Name	Servicing Facility and NPI/PIN Number		

Patient information

Primary Caregiver	Contact Number	☐Child ☐Spouse ☐Friend ☐Self ☐Paid Caregiver

Residence prior to admission to hospital: ☐Lives alone ☐Lives with family ☐Lives with paid caregiver ☐Homeless ☐Shelter ☐Assisted- living facility ☐Long- term care/NH

Admission information

Admission date to SNF/IRF	**Referring doctor (Name and NPI#)**

Physician address/phone number

Facility admitting diagnosis and ICD-10 code

Complications

Surgical procedure	Date

Medical history

Risk factors: ☐ Smoker ☐ Etoh abuse ☐Dementia ☐ Urinary incontinence ☐Chronic pain ☐ Recent amputation ☐Hx of falls <90 days ☐ Multiple medications ☐None

Clinical information

Vital signs: T_____ HR_____ R_____ BP_____
Height_____ Weight_____

Isolation Precautions:☐Yes ☐No If "yes," type:_____

Sensory Status: ☐Alert and oriented x _____
☐Confused ☐ Deaf ☐Blind
☐Ability to speak ☐Unable to read
☐Ability to follow simple commands

Primary language spoken _____

Diet:☐ NPO ☐ Regular ☐ Soft ☐ Mech soft ☐ Puree ☐ Liquid
Other:_____
Tube feeding:☐Yes☐No If "yes," type:_____

Respiratory: 02 Sat: _____ ☐Room Air☐ On 02
02 delivery: ☐ None Type:_____
Resp tx ☐Yes ☐No Freq/Type:_____
Trach: ☐Yes ☐No
Vent: ☐Yes☐No Weaning: ☐Yes☐ No
Settings: _____
Suction ☐Yes ☐ No #/24H:_____
Route: ☐Nasal ☐Trach ☐Oral

Bowel: ☐ Continent ☐ Incontinent
Bladder:☐ Continent ☐ Incontinent
Cath/type:_____

Mobility and functional status

Prior level of functioning (home) | **Current level of functioning**

Focus goal of physical therapy:

Date of PT/OT notes: (include initial therapy evaluation and most current notes):

Bed mobility: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Transfers: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Stairs: Current number of stairs can climb_____

Number of stairs at home_____

Stairs/assist needed: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Gait/distance: _____

Gait assist needed: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Gait assist device: ☐ None Type:_____

Needs assist with device: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Comments:

Self-care current functioning

Focus occupational therapy goals:

Dressing/UE: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Feeding: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Telephone Use: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Speech therapy current status

☐ **None** ☐ **Dysphagia evaluation/modified barium swallow**

Result/aspiration risk/recommendations:

Comment:

Clinical information continued

Pain location:_____

Pain scale: _____ ☐ **Before medication** ☐ **After**

Medication:_____

Pain medication	**Route**	**Dose**	**Frequency**

Skin status: ☐ Intact

If not intact, complete fields below and attach additional information as necessary.

Wound or incision/location and stage:

Size: LxWxD(CM):

Is wound new? ☐ **Yes** ☐ **No**

Is wound chronic? ☐ **Yes** ☐ **No**

If chronic, is it Skilled Wound Care? ☐ **Yes** ☐ **No**

Treatment:

Medications

List significant medication changes at reassessment that affect functioning:

IV/PICC line: ☐ **Yes** ☐ **No**

List IV medications (medication name, dose, frequency, start date, end date):

Medication name:

Dose: | **Frequency:**

Start date: | **End date:**

Discharge plans (must be initiated upon admission to PAC facility)

Discharge date (tentative) | **Home evaluation date**

Discharge location ☐ **Home alone** ☐ **HHC/Company** ☐ **Family/Support** ☐ **Other** ☐ **Assisted living** ☐ **Long- term care** ☐ **Adult foster care**

Equipment:

Supervision needs:

Home/number of levels: ☐ **1** ☐ **2** ☐ **3**

Other:_____

Home/number of steps at: Entry_____

Bed/Bath:_____

Discharge barriers: