Concurrent Review Authorization Form

For Concurrent Review Requests: Fax to **800.575.4429** or call **800.298.4806** 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? (choose only one answer) Yes No
- Has this member started receiving services for this request? Yes No
- Has this member already been discharged from this service? 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 within the last 24-48 hours)

Assessment Type

Facility Type Requesting: SNF ______ SNF Level IRF LTAC	**Estimated Length of Stay** (# of days)

Member/Facility Information

Member Name	Date of Birth	Member Address
Policy Number	Member Phone Number	PAC Facility Admission Date
Servicing Facility Name	Servicing Facility Address	
Servicing Facility Phone	Servicing Facility Contact Name	Servicing Facility NPI

Member 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

Admitting Doctor	Admitting Doctor Address/Phone Number

Along with this form, please submit the following (if applicable) with your recertification request. Any missing required information could result in an unnecessary delay or potential denial:

Total minutes of therapy per week (please indicate minutes here) __________
Total minutes of therapy per day (please indicate minutes here) __________
Prior and current level of functioning
PT/OT/ST evaluations/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
Home evaluation: Number of steps at home/level of assistance needed
Wound details: Wound size, location, treatments
Complete Medication List
Discharge Plan/Barriers