EviCore By EVERNORTH

Concurrent Review Prior Authorization Form

For Concurrent Review Requests: Fax to 877-502-0810 or call 888-622-7329 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. Prior authorization and authorization for continued stays are not a guarantee of payment.

Disclaimer statements and attestation

Verify eligibility and benefits prior to request. SNF/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? ☐ 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

Requested Service Type: ☐ SNF _____ SNF Level ☐ IRF

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 **(Required)**

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

Ordering Physician	Ordering Physician Address/Phone Number	Diagnosis Code

Along with this form, please submit the following (if applicable) with your prior authorization 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