EviCore By EVERNORTH

SNF & IRF
Post-Acute Care Initial Prior Authorization Form

INITIAL POST-ACUTE CARE REQUESTS: Fax to 855-633-8631 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 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; 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/Coverage

Requested Service Type: ☐ SNF ☐ IRF

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 Contact Name
Servicing Facility Name	Servicing Facility Address	
Servicing Facility Phone	Servicing Facility Contact Name (if known)	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

Expected Admission Date to PAC facility	Ordering Physician	Ordering Physician Address/Phone Number	Admitting 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:

- ☐ 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) _____