

Authorization Request for SNF, Acute Rehab and LTAC



Date of request: _____

Email: inpatientnotification@healthchoiceutah.com

(Please send email encrypted to protect PHI)

Phone: 877-358-8797

Fax: 801-758-3380

Our goal is to provide the most appropriate and timely care for our mutual patients. To this end, please provide the list of documentation listed in page #2 to expedite the review for medical necessity.

Please submit completed request by 3:00 pm to allow enough time for review.

Patient Name: _____ DOB ___/___/___ ID# _____

Requesting Facility Information

Requesting Facility: _____

Level of Care Requested:

- SNF (Swing bed)-Level I LTAC- Level I
 SNF Long term (Prism process-No therapies) Acute Rehab

Admissions Date: _____ Anticipated Length of Stay: _____

Admissions Contact: _____ Phone: _____

Concurrent Review Contact: _____ Phone: _____

Admissions Fax: _____ Concurrent fax (if different): _____

Address: _____

Facility Tax ID: _____ Facility NPI: _____

Initial review: Please submit list of documents listed on page #2 of this form for initial medical review.

For ongoing stay authorization beyond the initial days, please submit list of documents listed on page #2

Please notify us *immediately* if member leaves against medical advice (AMA)

Note: Please submit clinical documents with time stamped note, signed by author.

Initial Request	
Skilled Nursing Facility, Acute Rehab and LTAC Admission	
	H&P from hospital
	Current Physical and Occupational Therapy Notes from hospital
	IV Antibiotics start and end date (if applicable)
	Skilled Wound Care (site/measurement/description)
Concurrent Review	
Skilled Nursing Facility, Acute Rehab and LTAC Concurrent review	
	All therapy notes for applicable date span
	PT/OT Minutes
	Any adjustments on medication(s) being used
	Updated treatment plan including barriers to discharge
	Discharge Plan