

# Authorization Request for SNF, Acute Rehab and LTAC



**Email:** [uuhptransition@hsc.utah.edu](mailto:uuhptransition@hsc.utah.edu)  
(Please send email encrypted to protect PHI)  
**Phone:** 801-587-6480 Option #2  
**Fax:** 801-213-2132

Date of request: \_\_\_\_\_  
No. pages included in this request: \_\_\_\_\_

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:	
<input type="checkbox"/> SNF (Swing bed)-Level I	<input type="checkbox"/> LTAC- Level I
<input type="checkbox"/> SNF (Swing bed)-Level II (Medicaid Excluded)	<input type="checkbox"/> LTAC- Level II (Medicaid Excluded)
<input type="checkbox"/> SNF (Swing bed)-Level III (Medicaid Excluded)	<input type="checkbox"/> LTAC- Level III (Medicaid Excluded)
<input type="checkbox"/> SNF Long term (Prism process-No therapies)	<input type="checkbox"/> 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: _____

For questions regarding Revenue codes, please refer to your contracts.

**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.**

<b>Initial Request</b>	
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)
<b>Concurrent Review</b>	
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