



Utilization Management
Phone: 1-877-284-0102 Fax: 1-800-510-2162

Skilled Nursing Facility Admissions Precertification Review

Date: _____ Reference #: _____ (provided after initial review)
A Utilization Management representative will fax you a reference number by the next business day after receiving this completed form. This reference number does not indicate an approval or denial of benefits, but only proof that the Plan has been notified. This information will be forwarded to the Plan's Managed Care Department. If you have any questions, please call Healthlink at 1-877-284-0102.

Facility or Agency Information

Name: _____
 Address: _____
 Phone: _____
 Fax: _____

Patient Information

Patient Name: _____
 ID Number: _____
 Patient DOB: _____
 Address: _____
 Phone: _____

Admitting Physician Information

Physician Name: _____
 Group Practice Name: _____
 Address: _____
 Phone: _____
 Fax: _____
 TIN: _____

Admission Information

Case Manager Name: _____
 Phone: _____
 Admission Date: _____

Treatment Information

Primary Diagnosis: _____
 Diagnosis (ICD-9) Code: _____
 Primary Procedure: _____
 Procedure (ICD-9) Code: _____
 Procedure Date: _____
 Referring MD: _____
 Phone: _____
 Estimated Length of Stay: _____

Benefits depend upon the eligibility of the patient at the time of admission, subject to all other Plan limitations, pre-admission review requirement and prior related claims. Verification of eligibility and description of benefits are based upon the information we have on file and does not guarantee payment.

Pertinent Medical History: (submit history, physical and/or hospital discharge summary with this form) _____

Does the individual require skilled nursing or skilled rehabilitation services that must be performed by, or under the supervision of, professional or technical personnel? YES NO

Does the individual require these skilled services on a daily basis? YES NO

Can the daily skilled services be provided only on an inpatient basis in a skilled nursing facility (SNF) setting?
 YES NO

Are skilled services ordered by a physician and necessary for the treatment of an illness or injury? YES NO

Is admission for observation, assessment and monitoring of a complicated or unstable condition? YES NO

If yes, please specify _____

Is complex teaching of services required? YES NO

If yes, please describe individual's condition and treatment _____

Is there a new complex medication regimen? YES NO

If yes, please describe regimen (drug names, route, and frequency) _____

Are IV medication(s) being given? YES NO

If yes, please document the IV medication(s) (drug names, dose, and frequency) _____

Is admission for initiation of tube feedings? YES NO

If yes, please describe type and frequency of tube feedings _____

Is admission for active weaning of ventilator dependent individuals? YES NO

Is admission for wound care (including decubitus/pressure ulcers)? YES NO

If yes, please indicate the size and stage of the wound and ordered treatment _____

Is admission for respiratory therapy (RT)? YES NO

If the patient is admitted for therapies (PT, OT, or ST) please complete the following information:

Prior Level of Function: _____

Current Ambulating Distance: _____

Is an assistive device required for ambulation? YES NO

Is the patient full weight-bearing? YES NO

If no, please specify: _____

Is the patient alert and oriented to person, place, and time? YES NO

If no, please specify: _____

Is the member able to tolerate three (3) hours of therapy per day? YES NO

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Current Level of Function/ Level of Assistance Required to Complete Tasks/Functions:

(Please select the correct level of function for each task/function listed below)

Task/Function	Not Assessed	Dependent	Max Assist	Mod Assist	Min Assist	Contact Guard	Standby Assist	Supervision	Independent
Transfers									
Bed to chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit to stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tub/Shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeding/Nutrition									
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing									
Upper Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting									
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing									
Upper Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication									
Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interaction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problem-Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Home Status/Social Support/Potential Discharge Barriers: _____

Describe the Treatment Plan (include frequency of PT, OT, and ST): _____

Goals

Short-Term Goals:

1. _____
2. _____
3. _____

Long-Term Goals:

1. _____
2. _____
3. _____

Discharge Information

Discharge Date: _____

Discharge Plans: _____

Anticipated Discharge Needs: SNF HHC HI* DME* Outpatient PT HOSPICE

**Preferred Providers available*

Patient Emergency Contact: _____ Phone: _____

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Provider Contact Information

Contact Person: _____

Title: _____

Phone: _____

Fax: _____