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-10) Code: _______________

Primary Procedure: ___________________________

Procedure (ICD-10) 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	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit to stand	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toilet	☐	☐	☐	☐	☐	☐	☐	☐	☐
Tub/Shower	☐	☐	☐	☐	☐	☐	☐	☐	☐
Feeding/Nutrition									
Feeding	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bathing									
Upper Body	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Body	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toileting									
Toileting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dressing									
Upper Body	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lower Body	☐	☐	☐	☐	☐	☐	☐	☐	☐
Communication									
Comprehension	☐	☐	☐	☐	☐	☐	☐	☐	☐
Expression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Social Interaction	☐	☐	☐	☐	☐	☐	☐	☐	☐
Problem-Solving	☐	☐	☐	☐	☐	☐	☐	☐	☐

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: ______________________

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