



## CONCURRENT AUTHORIZATION REQUEST

### SNP | SIP | IRF | LTACH

Submit this completed form by fax to **1-833-610-2399**, or on our provider portal:  
<https://secure.healthx.com/ProCareAdvantage.Provider>  
 Call 1-844-206-3719 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless emergent, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

Routine/Standard       Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION		
Member Name:	Member ID:	
Date of Birth:	Authorization number:	
CURRENT LEVEL OF CARE		
<input type="checkbox"/> SNF	<input type="checkbox"/> Inpatient Rehab	<input type="checkbox"/> LTACH
CM/SW Name:	Phone Number:	Fax Number:
Prior Living Conditions: <input type="checkbox"/> Independent <input type="checkbox"/> Lives with others <input type="checkbox"/> SNF <input type="checkbox"/> ALF/ILF		
Owned DME: <input type="checkbox"/> Cane (SP/Quad) <input type="checkbox"/> Walker <input type="checkbox"/> Rollator <input type="checkbox"/> W/C <input type="checkbox"/> Power w/c or Scooter <input type="checkbox"/> BSC		
<input type="checkbox"/> Other:		
BRIEF CURRENT MEDICAL STATUS UPDATE		
Provide brief update on member status/diagnosis/medical condition (If there is a decline, please state reason):		
Wound Location, size:	Wound treatment/dressing type and frequency:	
IV Antibiotics: please include name/frequency/duration:		
Name: _____ Frequency: _____ Duration: _____		
Name: _____ Frequency: _____ Duration: _____		
Name: _____ Frequency: _____ Duration: _____		
PT Updates Bed mobility: Transfers: Ambulation:	OT Updates Feeding: Bathing: Dressing: Toileting:	ST Updates: Language/Expression: Cognition: Diet:



Anticipated Discharge Date:

D/C Barriers:

**CLINICAL INFORMATION**

- Clinical/ therapy documentation/ assessments should be within 72 hours of request.
- Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.
- Missing this information may delay the decision on your request or may result in Lack of Information denial.

Provider Attestation: By signing below, I certify that the patient’s medical records accurately reflect the information provided. I understand that ProCare Advantage may request medical records for this patient at any time in order to verify this information. I further understand that if ProCare Advantage determines this information is not reflected in the patient’s medical records, ProCare Advantage may request a refund of any payments made and/or any other remedies available.

Please certify the following by signing and dating below:

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please fax form to: 1-833-610-2399