



## SKILLED NURSING AUTHORIZATION REQUEST FORM

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:   | Member Living Facility:  |             |
| REQUESTING PROVIDER/FACILITY   |  |             |
| Requestor's Name (Print):  | Phone Number:  | Fax Number: |
| Referring Provider (If other than requestor):  | Referring Provider:<br><input type="checkbox"/> NP/PA <input type="checkbox"/> PCP <input type="checkbox"/> Therapy Rep <input type="checkbox"/> Other |             |
| NPI/TIN Number:  | Date of Request:   |             |
| SERVICING PROVIDER/FACILITY  |  |             |
| Admitting/ Servicing Facility/ Provider Name:  |  |             |
| NPI/ TIN Number:   | Phone Number:  | Fax number: |
| SERVICE TYPE REQUESTED   |  |             |
| <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension Request, Previous Auth #:  |  |             |
| Skilled Nursing Services: (Select one)   |  |             |
| <input type="checkbox"/> Post-Acute Skilled Nursing Facility (SNF)<br><input type="checkbox"/> Skill-In-Place (SIP)<br><input type="checkbox"/> Direct SNF admission |  |             |
| Days/ Visits Requested:  | Admission Date/ Date of Service:   |             |
| CPT Code (or Description of service being requested):  |  |             |
| Current Primary Diagnoses and ICD-10 Code(s):  |  |             |



#### 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 (LOI) denial.

#### OUT-OF NETWORK SERVICES ONLY

- Has the service been scheduled already? Yes No
- Is this a specialized service that no other In-network provider can render? Yes No
- Does the member have an established relationship with the provider that should not be interrupted? Yes No  
If "Yes", explain (include last visit date):