PARAMOUNT

ELITE | COMMERCIAL/HMO

Skill Nursing Facility Prior Authorization Form
Attn: SNF Coordinator
Toll Free Phone Number: 1-800-891-2520
Fax: 567-661-0848

SIX CLICK SCORE: _____ Request Faxed: Date & Time _____

Member Name: _____ Paramount Member ID #:_____

DOB: _____Age: _____ Paramount Secondary ID#:_____
(if applicable)

Sending Facility: _____ NPI#: _____

Date of Admission to Hospital: _____

D/C Planner: _____ Phone Number:_____

Name of Skilled Facility where member will be admitted to: _____

SNF's Tax ID #: _____ SNF's NPI #: _____

Admitting MD: _____

Consulting MD: _____ PCP: _____

Admitting Diagnosis and Diagnosis Code: _____

Co-Morbidities:_____

_____

Medical/Surgical History:_____

_____

Special Needs/Precautions: _____

_____

Wound Assessment and Monitoring Skin: Intact Other: _____ Wound Vac: _____

Dialysis: _____ Days of Week: _____ Nephrologist: _____

Mental Status: Alert/Oriented x's _____ Cooperative Confused Forgetful Agitated Impulsive

Safety: Fall Risk: _____ Add'l Precautions: _____Hip _____ Cardiac Other: _____

Special Equipment:_____

Cultural Considerations: _____ Interpreter Needed?: Yes No

Other: _____

On-Going Medical Needs**:** Pain Mgmt: _____ Location: _____ DVT Prophylaxis: _____
Lab monitoring: _____ GI Prophylaxis: _____ O2: _____ Trach: _____
Other: _____
Infection: _____ Isolation: _____ Other: _____ Medication Adj./Review: _____
Solid Organ Transplant Request: Yes No

Nutritional Status: _____ Elimination: _____
HT:_____ WT: _____ Urinary: Incontinent _____ Continent _____ Foley _____

Diet: _____ Bowel: Incontinent _____ Continent _____

Member Name:_____

Swallowing concerns: WFL Dysphagia Additional Notes: _____

NG Tube/PEG Tube:_____ IV/IV Med/cost per day: _____

TPN: _____

Premorbid Level of Function: _____

_____

Speech Services: N/A Dysphagia:_____ Cognition:_____ Speech/Language:_____

Physical Therapy Date:_____

Current Level of Function

Bed Mobility: IND SBA CGA MIN MOD MAX DEP x____

Supine>Sit: IND SBA CGA MIN MOD MAX DEP x____

Sit>Stand: IND SBA CGA MIN MOD MAX DEP x____

Ambulation:_____

Activity Limitations: _____

_____

WT Bearing Status:_____

Occupational Therapy Date:_____

Current Level of Function

Feeding: IND S/U CGA MIN MOD MAX DEP x____

Grooming: IND S/U CGA MIN MOD MAX DEP x____

Bathing UE: IND S/U CGA MIN MOD MAX DEP x___

Dressing UE: IND S/U CGA MIN MOD MAX DEP x___

Dressing LE: IND S/U CGA MIN MOD MAX DEP x___

Toileting: IND S/U MIN MOD MAX DEP x___

Activity Limitations:_____

Home Environment: Lives Alone:_____ Lives With: _____ Available 24 hrs /day: Yes ☐ No ☐

Additional Support System: _____ Home Style:_____ Entry Stairs: _____ Bed/Bath:_____

Discharge Destination: Home:_____ Alternate Plan:_____

DME:_____

OT_____ PT _____ ST_____

Is there a need for 24hr physical supervision? Yes ☐ No ☐

Willing/able to participate and tolerate therapy program? Yes ☐ No ☐

Prognosis/Expected Level of improvement:_____

Expected length of stay:_____

Name of person completing precert form: _____

Phone #:_____ Fax #:_____

Revised 6/2024