

**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 &amp; 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: \_\_\_\_\_

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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

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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 #: \_\_\_\_\_

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