Post-acute facility authorization form

Includes sub-acute rehab (SAR), skilled nursing facility (SNF), acute rehab and long-term acute care hospital (LTACH)

Fax form to 616.975.8848

Missing or incomplete information, including required medical records, may result in delays. Please allow 24-48 hours to process admission review and continued stay requests.

- **Admission review:** Upload all medical records needed to support your request. You must include physical (PT) and occupational therapy (OT) evaluations.
- **Continued stay (more days are required for patient's current admission):** Submit medical records and supporting documentation. Therapy records must be done within the last 48 hours of extension request.

Physical Therapy signature: _____ **Date:** _____

Occupational Therapy signature: _____ **Date:** _____

Background information		
Date of request: _____		
Check if your facility is:	☐ Participating as an **in-network provider for Cigna** ☐ Participating as an **in-network provider for Multiplan**	
Admitting from:		
☐ Inpatient hospital	☐ Long-term care facility	☐ Inpatient psychiatric facility
☐ Emergency dept.	☐ Inpatient acute rehab	☐ Observation
☐ Home	☐ LTACH	☐ Subacute rehab/skilled nursing facility
Admitting to:		
☐ Subacute rehab/skilled nursing facility	☐ Inpatient acute rehab	☐ LTACH

Member information			
Member last name		**Member first name**	
Priority Health ID#		**Date of birth**	

Facility information & post-acute benefits			
Admitting facility		**Contact name**	
Facility address			
Facility tax ID		**Facility NPI**	
Contact phone #		**Contact fax #**	

Admission Information			
Admission date		**Procedure date**	
Diagnosis code(s)		**Procedure**	
Diagnosis		**Complications**	
Estimated length of stay (ELOS)			

**Priority Health requires authorization for home care and some DME equipment*
Please use the Medical Authorization Form.

Priority Health

Mobility	
Gait/Assist level: ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total	**Assistive device:**
Distance/feet:	**Stairs/number of stairs/assist level:**
Bed mobility: ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total	**LB bathing:** ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total
Transfers: ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total	**LB dressing:** ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total
UB dressing: ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total	**Grooming:** ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total
UB bathing: ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total	**WBS:**
Toileting: ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total	**Additional information:**
Eating: ☐ Ind ☐ ModI ☐ SBA ☐ CGA ☐ Min ☐ Mod ☐ Max ☐ Total	

Cognition	
Alert and oriented to	☐ Person ☐ Place ☐ Time ☐ Situation ☐ Other (deaf, blind, etc):
Mental health concerns	
Dementia	☐ Yes ☐ No Comments:

Speech Language Pathology			
SLP indicated	☐ Yes ☐ No	**Aspiration risk**	☐ Yes ☐ No
Modified diet		**Treatments**	
Tube feeding type			
Formula and frequency			
Start date			

Respiratory			
O2 saturation		**O2 Delivery Mode**	☐ None Type:
Vent	☐ Yes ☐ No	**Vent settings**	
Trach	☐ Yes ☐ No	**Trach type**	
Suction and frequency			

Pain			
Pain	☐ Yes ☐ No	**Location**	
Medication (s)			
Name:	**Dose:**	**Route:**	**Frequency:**
Name:	**Dose:**	**Route:**	**Frequency:**
Adjustments			

**Priority Health requires authorization for home care and some DME equipment*
Please use the Medical Authorization Form.

IV/PICC line medications			
Name:	**Dose:**	**Start Date:**	**End Date:**
Name:	**Dose:**	**Start Date:**	**End Date:**
Adjustments			

Skin Status			
Skin intact?	☐ Yes ☐ No		
Wound/Incision #1			
Location		**Size** (LxWxD cm)	
Stage		**Treatment** (type, frequency)	
Wound/Incision #2			
Location		**Size** (LxWxD cm)	
Stage		**Treatment** (type, frequency)	
Additional comments			

Describe the nursing plan of care:

Discharge plans (must be initiated at admission)			
Discharge date		**Discharge location**	
Discharge goal			
Number of home levels		**Number of steps**	
Home evaluation date		**Lives with**	
Home care company		**Services**	
Equipment needs			
Discharge barriers			

Additional information:

**Priority Health requires authorization for home care and some DME equipment*
Please use the Medical Authorization Form.