Post-acute facility admission guide

This guide is intended to help facilitate the review process for both the admission to a post-acute facility (Skilled Nursing Facility [SNF] and Acute Rehabilitation Facility) and concurrent reviews. Please have this information available before calling for a precertification (authorization) request.

Please do **not** fax or submit this information to us.

For review of an admission to a Post-Acute Facility, please call 1-800-275-2583.

For concurrent reviews, please call 1-866-319-6954.

SNF or Acute Rehabilitation Facility Precertification/Concurrent review request:

Date of admission: ________________________________
Eligibility verified: ________________________________
Admitted from: ________________________________
Requesting physician name/phone number: ________________________________
Clinical Dx for this admission: ________________________________
PMHx/Co-morbid conditions: ________________________________
PTA prior level of function/Home environment: ________________________________
Anticipated D/C plan/Caregiver availability/Able-bodied caregiver: ________________________________
Barriers to discharging to home with services: ________________________________
Responsible party and phone number: ________________________________
DME items in home/DME needs: ________________________________
Previous HC agency used: ________________________________
Level of care/Used/Bed type: ________________________________
If rehab subacute level of care, number of therapy minutes: ________________________________
Attending physician: ________________________________
Phone number: ________________________________ NPI: ________________________________
Facility fax number: ____________________________ Facility NPI: ________________________________

Cognitive/Behavioral status: A & O x ________________________________
Height: _______________ Current weight: _______________
Diet: ________________________________ Appetite: ________________________________
Tube feeding type: ________________________________ Date inserted: ____________________
Feeding product/Volume/Frequency per day: ________________________________
   Method of delivery: ________________________________
Speech Tx: ________________________________
Skin intact: ________________________________
Wound site/Origin/Measurement/Color/Drainage/Treatment: _________________________
O2/Ventilator/Trach settings: _________________________ O2 saturation reading (%):_______
Blood glucose monitoring frequency/Result range: ________________________________
Blood sugar coverage: ________________________________
Pain issues/Site: ________________________________ Pain treatment: ________________
Vascular access(es): ________________________________
Significant Meds/IV or SQ Meds/Fluids (Including Dosage & Frequency): ____________
Lab values: ________________________________
Current medical issues: ________________________________
Upcoming appointments: ________________________________

Functional Assessment Date: ________________________________

**STATUS KEY:** A=Admission; C=Concurrent review; G=Goal (Admission status information is not required at time of concurrent reviews.)

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Conference date: ________________________________
Family training: ________________________________
Estimated date of discharge: ________________________________

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