Skilled Nursing Facility Request Form

Member Information

First Name:_____ MI:_____ Last Name:_____

Partnership Member ID:_____ Date of Birth:_____

Requestor Information

Facility:_____ NPI Number:_____

Facility Contact Name:_____ Phone Number:_____

Reason for Admission:_____

Admission Date:_____ Requested Length of Service:_____

Anticipated Discharge Plan:_____

Requested Services (Check all that apply)

Custodial Services Only: ☐

Requested Skilled Therapy Code (check specific modalities below):_____

Was a verbal authorization given for this request? Yes ☐ No ☐

	Ordered	Frequency	Duration (Days)	Additional Information
Physical Therapy				
Occupational Therapy				
Speech Therapy				
IV Antibiotics				
Wound Care				
Additional Therapies				

Additional Comments: