SummaCare

PRIOR AUTHORIZATION REQUEST
INPATIENT SKILLED NURSING/TCU FORM

PLEASE FILL OUT THE FORM IN ITS ENTIRETY AND FAX TO 234-542-0811 ALONG WITH H&P, INITIAL THERAPY EVALUATIONS, THERAPY NOTES WITHIN 24 HOURS, MOST RECENT MD PROGRESS NOTE, MEDICATION LIST, AND VITAL SIGNS.

SOCIAL WORKER/CASE MANAGER_____ CONTACT#_____

***HAS THE SERVICE BEING REQUESTED ALREADY BEEN PERFORMED? YES ☐ NO ☐**

MEMBER INFORMATION

Last name:	First name:	M.I.	DOB:	Member ID:

REFERRING PHYSICIAN INFORMATION

Last name:	First name:	M.I.	Tax ID:	NPI#:

SKILLED FACILITY INFORMATION

Facility requested:	SNF NPI#:	SNF Tax ID#:
Address:		
Phone #:	Phone #/Option/Ext:	Fax #:
Other contact name:	ICD-10 Code:	Admission Date:

PRIOR FUNCTION/LIVING ARRANGEMENTS

Function prior to admission (lives alone, uses walker, bed/bath second floor, # of steps in entry, checked on daily, etc.) _____

_____

☐ Lives alone ☐ Lives w/family ☐ House ☐ Apartment
☐ Equipment
☐ ADL Other: _____

CARDIAC/RESPIRATORY STATUS

☐ Oxygen Flow rate: _____ Pulse ox: _____

☐ Intubated/Trach Care ☐ Vent

BP: _____ Pulse: _____ Respirations: _____ Temp: _____

ANTICIPATED DISCHARGE PLAN FROM SNF

☐ Home Alone ☐ Assisted Living ☐ Long Term Care
☐ Homecare ☐ Home With Family
Patient ability to progress at SNF: ☐ Good ☐ Fair ☐ Poor
Patient goal: _____

NUTRITIONAL STATUS

Diet: _____
Tube Feedings: ☐ Yes ☐ No Type of tube feeding/name: _____
Amount: _____ ☐ Continuous ☐ Bolus
Frequency: _____

CURRENT TREATMENTS INFUSION STATUS

IV meds: _____ Frequency of infusion: _____End date of infusion: _____
TPN: _____

CURRENT TREATMENTS WOUND STATUS (INCLUDE WOUND CARE NOTES)

Location: _____ Size: _____ Stage: _____
Treatment: _____

Pain: Specific medication treatment and frequency: _____
_____ Pain Level: _____

URINARY/RENAL/BOWEL STATUS

Dialysis: ☐ Hemodialysis Port: _____ ☐ Peritoneal ☐ Ostomy Type: _____
☐ Foley/Suprapubic/Other Size: _____ Last changed: _____ Going with member? ☐ Yes ☐ No

PHYSICAL THERAPY (SEND EVALUATON AND MOST CURRENT TREATMENT NOTES WITHIN 24 HOURS)

Weight bearing status:	☐ Not applicable	☐ Non Wt Bearing	☐ Total Wt Bearing	☐ Partial Wt Bearing			
Bed mobility:	☐ Independent	☐ Supervision	☐ Mod I	☐ Contact Guard Assist	☐ Min Assist	☐ Mod Assist	☐ Max Assist
Transfer:	☐ Independent	☐ Supervision	☐ Mod I	☐ Contact Guard Assist	☐ Min Assist	☐ Mod Assist	☐ Max Assist
Ambulation #_____ ft	☐ Independent	☐ Supervision	☐ Mod I	☐ Contact Guard Assist	☐ Min Assist	☐ Mod Assist	☐ Max Assist
Device:	☐ None	☐ Cane	☐ Walker	☐ Wheelchair			
History of falls:	☐ Yes	☐ No					

OCCUPATIONAL THERAPY (SEND EVALUATON AND MOST CURRENT TREATMENT NOTES WITHIN 24 HOURS)

UB ADL:	☐ Independent	☐ Supervision	☐ Mod I	☐ Contact Guard Assist	☐ Min Assist	☐ Mod Assist	☐ Max Assist
LB ADL:	☐ Independent	☐ Supervision	☐ Mod I	☐ Contact Guard Assist	☐ Min Assist	☐ Mod Assist	☐ Max Assist

SPEECH THERAPY (SEND EVALUATON AND MOST CURRENT TREATMENT NOTES WITHIN 24 HOURS)

COGNITION:	☐ Within normal limits	If impaired:	☐ Mild	☐ Moderate	☐ Severe
SWALLOW:	☐ Within normal limits	If impaired:	☐ Mild	☐ Moderate	☐ Severe