Skilled Nursing Facility-Concurrent Review Request
Attn: SNF Coordinator
Toll Free Phone Number: 1-800-891-2520
Fax: 567-661-0848

Member Name: _____ Paramount Member ID#: _____

Authorization Number: _____ Paramount Secondary ID#_____
(if applicable)

Attending Physician: _____ Admission Date: _____

Diagnosis: _____

Facility Name: _____ Provider Billing Tax ID (TIN): _____

Facility Contact/Phone Number: _____

Date of Review						
Level of Care Requested: Please Circle	IH0191 IH0193	IH0192 IH0194	IH0191 IH0193	IH0192 IH0194	IH0191 IH0193	IH0192 IH0194
Neuro/Behavior:						
Respiratory: Lung Sounds/Treatments O2/Ventilator						
Cardiovascular/Vital Signs:						
Skin/Wounds/Treatments:						
GI/GU:						
Nutrition/Diet:						
PO/IV Meds/Insulin Dose (sliding scale):						
Lab/Dx Tests: Include Blood Sugars Frequency:						
Patient/Family Education:						
Cognition:						
Speech/Swallowing:						

Member Name: _____ Paramount ID#: _____

Authorization #: _____

Date of Review:			
Bathing & Dressing:			
Toileting:			
Cognition/Safety:			
Home Management:			
Weight Bearing Status: ROM Total Knee:			
Bed Mobility:			
Supine to Sit:			
Sit to Stand Stand to Sit:			
Gait/Assistive Device/ Distance/Assist	Device: W RW QC C I Distance Assist	Device: W RW QC C I Distance Assist	Device: W RW QC C I Distance Assist
Balance:			
Stairs:			
Discharge Plans/Goals (include HHC, DME) Discharge Date:			

Isolation: IHO1999 Dates: From: _____ To:_____

OTHER: _____

_____