Skill Nursing Facility Prior Authorization Form
Attn: SNF Coordinator
Toll Free Phone Number: 1-800-891-2520
Fax: 567-661-0848

SIX CLICK SCORE: _______ Request Faxed: Date & Time _____________________

Member Name: _________________________________ Paramount Member ID #: ______________________

DOB: _______________Age: ______ Paramount Secondary ID#:_____________________
(if applicable)

Sending Facility: _________________________________ NPI#: _______________________________________

Date of Admission to Hospital: _____________________

D/C Planner: ___________________________________ Phone Number: _______________________________

Name of Skilled Facility where member will be admitted to: _________________________________

SNF's Tax ID #: _________________________________ SNF's NPI #: ____________________________

Admitting MD: ___________________________________

Consulting MD: __________________________________ PCP: _______________________________________

Admitting Diagnosis and Diagnosis Code: ____

Co-Morbidities:____

____

Medical/Surgical History:____

____

Special Needs/Precautions: ____

____

Wound Assessment and Monitoring Skin: Intact Other: ______________ Wound Vac: ___________

Dialysis: ______________________ Days of Week: ______________ Nephrologist: _____________

Mental Status: Alert/Oriented x's _______ Cooperative Confused Forgetful Agitated Impulsive

Safety: Fall Risk: ________ Add'l Precautions: ___________Hip ________ Cardiac Other: ________

Special Equipment: ____

Cultural Considerations: ____________________________________ Interpreter Needed? Yes No

Other: ____

On-Going Medical Needs**:** Pain Mgmt: ________ Location: _________ DVT Prophylaxis: _________

Lab monitoring: __________ GI Prophylaxis: ____________ O2: ___________ Trach: ___________

Other: ____

Infection: __________ Isolation: _________ Other: __________ Medication Adj./Review: _________

Solid Organ Transplant Request: Yes No

Nutritional Status: ________________________ Elimination: ___________________________

HT: _____ WT: ______ Urinary: Incontinent ________ Continent ________ Foley ______________

Diet: ______ Bowel: Incontinent ________ Continent _________

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Attn: SNF Coordinator
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Member Name: ________________________________

Swallowing concerns: WFL Dysphagia

Additional Notes: ________________________

NG Tube/PEG Tube: _____________________

IV/IV Med/cost per day: ________________________

TPN: ____

Premorbid Level of Function: ____

____

Speech Services: N/A Dysphagia: ________ Cognition: ________ Speech/Language: ___________

Physical Therapy Date: _________

Current Level of Function

Bed Mobility: IND SBA CGA MIN MOD MAX DEP x____

Supine>Sit: IND SBA CGA MIN MOD MAX DEP x____

Sit>Stand: IND SBA CGA MIN MOD MAX DEP x____

Ambulation: ________________________________

Activity Limitations: __________________________

____

WT Bearing Status: ___________________________

Occupational Therapy Date: ________

Current Level of Function

Feeding: IND S/U CGA MIN MOD MAX DEP x____

Grooming: IND S/U CGA MIN MOD MAX DEP x____

Bathing UE: IND S/U CGA MIN MOD MAX DEP x___

Dressing UE: IND S/U CGA MIN MOD MAX DEP x___

Dressing LE: IND S/U CGA MIN MOD MAX DEP x___

Toileting: IND S/U MIN MOD MAX DEP x___

Activity Limitations: ______________________________

Home Environment: Lives Alone: _____ Lives With: ___________ Available 24 hrs /day: Yes ☐ No ☐

Additional Support System: ____

Home Style: ________________ Entry Stairs: _______________ Bed/Bath: _____________________

Discharge Destination: Home: ____________________ Alternate Plan: _____________________

DME: ____

OT_____________________ PT ____________________ ST________________________

Is there a need for 24hr physical supervision? Yes ☐ No ☐

Willing/able to participate and tolerate therapy program? Yes ☐ No ☐

Prognosis/Expected Level of improvement: ____

Expected length of stay: ____

Name of person completing precert form: ____

Phone #: ___________________________ Fax #:____________________________________

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