Skilled Nursing Facility (SNF) Pre-Service Request

Date: ______

Provider Information:

Servicing Provider:

Name: _________________________

Provider#:______________________

NPI#:__________________________

Address:_______________________

____

Phone#:(____)__________________

Fax#:(____)____________________

Contact Name/Phone#:

____

Ordering Provider:

Name_________________________________

Provider #: ____________________________

NPI#:__________________________________

Address:_______________________________

____

Phone#:(____)__________________________

Fax#:(____)____________________________

Contact Name/Phone#:

____

Medicare certified agency: Yes☐ No☐ (other certification) ______________________

____

Patient Information:

Patient Name_____________________

DOB:___________________________

Member ID#:_____________________

Address: ____

____

Subscriber Name: _________________

Group#:_________________________

Secondary Payer Source: Yes ☐ No ☐

Diagnosis code(s):_______________________

3 Day Qualifying Hospitalization: ☐/☐/☐ to ☐/☐/☐

Skilled Services: SN: __ PT: __ OT: __ ST: __ other: _____ & Frequency: _________________________

All the following information is RECOMMENDED to determine medical necessity:

*** Medical History**
*** Previous Level of Function**
*** Initial evaluations**
*** Plan of care with measurable goals**
*** Progress notes**
*** Discharge summary/plan**
*** Please fill out provided PT/OT Summary form**

Fax form to: 651-662-1004
Mail form to: Integrated Health Management, PO Box 64668,
St. Paul, Minnesota 55164-0668

PHYSICAL THERAPY SUMMARY

SKILL/TASK (Please indicate level of assistance)	Initial Status/ Evaluation	Week 1	Week 2	Week 3	Week 4	Long Term Goals
Bed Mobility						
Transfers						
Gait: -Distance -Assistive Device:						
Balance -Sitting: -Standing:						

OCCUPATIONAL THERAPY SUMMARY

SKILL/TASK (Please indicate level of assistance)	Initial Status/ Evaluation	Week 1	Week 2	Week 3	Week 4	Long Term Goal
Feeding						
Grooming/Hygiene						
Dressing UB						
Bathing UB						
Dressing LB						
Bathing LB						
ADL Transfers						

Level of Assistance Key:
Max A – Maximum Assistance
Mod A – Moderate Assistance
Min A - Minimal Assistance
Sup - Supervision
Mod I - Modified Independent
I - Independent