Postacute Care Prior Authorization Form
Skilled Nursing Facility, Inpatient Rehab and Long-term Acute Care

HealthSpring℠

Fax this form and all required documents to **855-662-7973**.

Please note that the following must accompany this form. Submission of incomplete information may result in processing delays.
- Face sheet if the patient recently had an acute stay or is currently in an acute stay
- Medication list
- Complete history and physical, including clinical updates or recent discharge summary

Also include physical therapy, occupational therapy and speech-language therapy information. Evaluations should occur within approximately 48 hours prior to the request date and time:
- Previous level of function
- Current level of function
- Current living situation
- Discharge plan information

Assessment type or coverage

Facility type ☐ SNF ☐ IRF ☐ LTAC

Member and facility information

Member name	Date of birth	Address
HealthSpring ID	Member phone	Requesting facility name
Anticipated date of transfer to postacute setting or start of care		
Requesting facility address		
Requesting facility phone		Requesting facility fax
Requesting facility reviewer name	Servicing facility, National Provider Identifier and Tax Identification Number	
Requesting NPI	Primary diagnosis ICD-10 code	Secondary diagnosis ICD-10 code

If the facility is out of network, are they willing to accept 100% Medicare allowable rate ☐ Yes ☐ No

Single case agreement required? ☐ Yes ☐ No

Reason for out-of-network referral, if applicable ☐ Yes ☐ No

Member information

Primary caregiver	Contact number	☐ Child ☐ Spouse ☐ Friend ☐ Self ☐ Paid caregiver

Residence prior to admission to hospital
☐ Lives alone ☐ Lives with family ☐ Lives with paid caregiver
☐ Homeless shelter ☐ Assisted living facility ☐ Long-term care/nursing home

Skilled needs

Skilled needs include wound care, IV antibiotics and other skilled procedures such as nursing needs or tube feeding. Please provide specifics.

IV antibiotics	Other IV therapies required	IV access	Complete wound care needs
Medication _____	Medication _____	☐ Peripheral	form if wounds are present.
Dosage _____	Dosage _____	☐ PICC	Wound vacuum in place
Start date _____	Start date _____	☐ Central	☐ Yes ☐ No
Stop date_____	Stop date_____		
Frequency _____	Frequency _____		

Skilled needs (continued)

Dialysis ☐ Yes ☐ No	Diabetic ☐ Yes ☐ No	Sliding scale insulin information ☐ Yes ☐ No	Related to congestive heart failure, chronic obstructive pulmonary disease or other ☐ Yes ☐ No
Supplemental oxygen needs ☐ Yes ☐ No	PEG or G-tube feeding is at goal rate ☐ Yes ☐ No		Treatment modalities to include ☐ PT ☐ OT ☐ ST
Respiratory therapy required ☐ Yes ☐ No Isolation ☐ Yes ☐ No Type _____	Ventilator setting, if applicable		Additional information

Type of wound				Location	Stage
Measurements	Drainage (type/odor/amount)	Slough	Type of dressing	Frequency of dressing change	
Type of wound				Location	Stage
Measurements	Drainage (type/odor/amount)	Slough	Type of dressing	Frequency of dressing change	

Peer-to-peer consultation information

Peer-to-peer consultation information is required for inpatient rehabilitation, long-term acute care hospital and retroactive requests. Peer-to-peer consultation information may also be requested in cases where skilled nurse facility requests do not meet medical necessity criteria.

Please provide the phone number of a hospital medical doctor, doctor of osteopathic medicine, physician assistant or nurse practitioner and the days and times they're available to conduct a peer-to-peer consultation. We require this information up front to avoid delays in processing time. Providers have the right to decline a peer-to-peer consultation.

To initiate a postacute stay request via phone or to check on the status of an existing request, call 800-887-9733, Monday - Friday, 8 a.m. - 5 p.m. CT.

If you're calling to initiate a request, you must still complete this form.

Provider name	Provider phone	Peer-to-peer declined ☐ Yes ☐ No	
This form completed by	Direct phone	Direct fax	Best time to contact