Skilled Nursing Facility Authorization Form
Fax completed form to: 608-252-0863

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION		
Referring Provider Name (do not list name of hospital as referring provider)		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:		

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Choose SNF or Swing Bed	SNF	Swing Bed

REQUEST INFORMATION			
Requested date of admission to SNF/swing bed:	Diagnosis Code(s):		
Member Admitted From: (e.g., hospital, home)			
3rd party liability. If yes, indicate:	W/C	MVA	Other
Payor Source:	Medicare A Primary	WellFirst HMO	WellFirst PPO/POS
Other/Comments			

Form Submitted By:		
Name:	Phone:	Fax:

For further information on skilled nursing facilities, please see the WellFirst Health medical policy Skilled Nursing Facility.

The completed form can be faxed to: 608-252-0863.
If you have any questions regarding the services or form, please contact our Customer Care Center at 866-514-4194 or review the WellFirst Health Medical Management site. Requests to non-plan providers must be approved prior to obtaining services.

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