

Skilled Nursing Facility Authorization Form Fax completed form to: 608-252-0830

PATIENT DEMOGRAPHICS							
Patient Name:				Date	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 provide					Phone #:		
Street Address:				Fax #:			
City: State:			Zip Co			le:	
Provider #:	Tax ID #:		NPI:			Specialty:	
REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION							
Referred To:					Phone #		
Street Address:				Fax#			
City: State:			T		Zip Code:		
Provider #:	Tax ID #:		NPI:			Specialty:	
Choose SNF or Swing Bed SNF			<u>L</u>			Swing Bed	
REQUEST INFORMATION							
Requested date of admission to SNF/swing bed:			Diagnosis Code(s):				
Member Admitted From: (e.g., hospital, home)							
3 rd party liability. If yes, indicate:					MVA	Other	
Payor Source:	Medicare A Primary Medica HMO					Medica PPO/POS	
Other/Comments							
Form Submitted By:							
Name:			Phone:			Fax:	

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

The completed form can be faxed to: 608-252-0830.

If you have any questions regarding the services or form, please contact Member Services at the number on the member's ID card. or review the Medical Management page. Requests to non-plan providers must be approved prior to obtaining services.

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