Independent Health Skilled Nursing Prior Authorization Form

IH Medical: Phone: (716)631-3425 Fax: (716)635-5329

Required: Please complete all fields to ensure timely processing.

DOES THE REQUEST REQUIRE EXPEDITED STATUS?	☐ **NO**	☐ **YES** (explain below)
Expedited requests are appropriate when time frame could seriously jeopardize the life of health of our members.		
Expedited rationale:		

Member Information			
	*Member Name:		
	DOB:	*Independent Health ID #:	
	Address:		
	City:	State:	Zip:

Facility Information		
	*Facility:	
	*Tax ID:	NPI:
	Facility Contact Name:	
	Facility Contact Phone #:	

Requesting Physician/Practitioner (first & last name): _____

Phone: _____ **Fax:** _____

Admit Date: _____ **Admit From:** ☐ **Home** ☐ **Hospital** ☐ **Nursing Home**

Level of Care Requested: ☐ **Skilled Nursing** ☐ **Subacute Rehab**

Facility Admitted From: _____

Diagnosis Code(s) (ICD-10): _____ _____ _____

Reason for Admission: _____

Treatment Plan: _____

Therapy Plan: _____

Functional Status Prior to Admission: _____

***The following information is REQUIRED to process your request:**

1. Copy of MD order for admission to Skilled Nursing Facility
2. Medical treatment needs not limited to (skilled therapies, wound care, IV medications etc.) along with frequency/duration
3. Documentation of current baseline level of function
4. Copy of nursing home assessment (if applicable)
5. Documentation of treatment precluded in a lower level of care

UnitedHealthcare® Options PPO Network

Independent Health®