AmeriHealth Caritas
VIP Care Plus

# Prior Authorization Form
## Skilled Nursing Facilities

Patient name:

Date of birth: Date of admission: Plan ID number: Benefit days: _____ /100

Facility name: Phone: Fax:

Facility case manager:

Diagnosis:

History of admission/synopsis:

Past medical history:

Social history:

Prior level of function:

Discharge plan:

Barriers to discharge:

### Medical review

| | Date | Date | Date | Date | Date | Date | Notes |
|---|---|---|---|---|---|---|---|
| **Orientation** | | | | | | | |
| **Vital signs** | | | | | | | |
| **Respiration** | | | | | | | |
| **Oxygen saturation ($O_2$ sats)** | | | | | | | |
| **Tracheostomy (trach)** | | | | | | | |
| **Ventilator (vent)** | | | | | | | |
| **Nebuliser (nebs)** | | | | | | | |
| **BiPAP** | | | | | | | |
| **Tube feedings** | | | | | | | |

## Rehabilitation

| | Goals | Current | Date | Date | Date | Date | Notes |
|---|---|---|---|---|---|---|---|
| **Gait** | | Distance:<br>Assistive device:<br>Level of assistance: | | | | | |
| **Stairs** | | | | | | | |
| **Bed mobility** | | | | | | | |
| **Transfers** | | Sitting:<br>Standing: | | | | | |
| **Feedings** | | | | | | | |
| **Grooming** | | | | | | | |
| **Bathing** | | Upper body:<br>Lower body: | | | | | |
| **Toilet** | | Transfer:<br>Hygiene: | | | | | |
| **Cues** | | | | | | | |
| **Balance** | | | | | | | |
| **Strength** | | | | | | | |
| **Tolerance** | | | | | | | |
| **Home management** | | | | | | | |
| **Speech** | | | | | | | |

**Notes:**



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