

Fax completed form to 1-866-263-9036.

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 (O₂ sats)							
Tracheostomy (trach)							
Ventilator (vent)							
Nebuliser (nebs)							
BiPAP							
Tube feedings							

**Prior Authorization Form
Skilled Nursing Facilities**

Rehabilitation

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

Notes: