CARE WISCONSIN

Skilled Nursing Facility and Long Term Acute Care Prior Authorization Request

Please provide the following clinical information to support medical necessity of all requests and fill form completely.

- H&P
- Discharge Summary
- Therapy Notes
- MD Progress Notes
- Labs/Radiology Studies
- Supporting Nursing Notes

Member Name:	D.O.B.:	Medicaid ID #:
Member Phone:	Member address:	
Requesting Provider Name/Clinic:		Tax ID:
Address:		
Clinical Contact/Title:	Phone:	Fax:
Facility Name:		Tax ID:
Address:		
Facility Utilization Review Dept./ Clinical Contact/Title:	Phone Number:	Fax:
Facility Medical Records Dept. Phone Number:		Fax:

Type of Request: ◉ Elective ○ Urgent ○ Retrospective (only within 14 business days from urgent/emergent admission

Date of admission: / / 2019

Admitting ICD10 Code:

Admission Type: ☐ SNF Rehabilitative - Medicare ☐ SNF Rehabilitative - Medicaid ☐ SNF - Hospice ☐ SNF Long Term Care/Custodial ☐ LTACH

Privacy and Confidentiality:
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No Guarantee of Payment

A prior authorization or precertification does not imply or guarantee payment, nor is it a verification of a member's eligibility at the point of service. Payments of benefits are subject to all terms, conditions, limitations, and exclusions of the program's contract and eligibility of the member at the time services are rendered.