care n care
Insurance Company, Inc.

Care Management

SNF, LTAC, REHAB Request

Health Plan/Payor:

☐ Care N' Care HMO ☐ Care N' Care PPO

Patient's Current Location (If Facility, name of Facility is Needed)

☐ ER: _____ ☐ Acute: _____ ☐ LTAC/REHAB:_____
☐ Office ☐ Home ☐ Other:_____

Request for:	☐ SNF	☐ LTAC	☐ REHAB	Today's Date: / /

Patient's Name:	DOB / /	Member ID:
Patient PCP:		NPI:
Requestor Name:		
Requestor Phone:		FAX:

Expected Admit Date: / /	
Ordering Physician:	Ordering Physician NPI:
Facility:	Facility NPI:
Treating Physician:	Treating Physician NPI:

ICD-10 CM Diagnosis Description	ICD-10 CM Code

Describe any special circumstances which should be considered when authorizing services:
Clinical Information: ****Clinical Information MUST be included with Request including eval and clinical notes from referring facility****

This request will be treated as per the standard organization determination timeframes. If the request needs to be treated as expedited, clinical justification must be provided that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function:

_____

_____

_____

Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.