

Care Management SNF, LTAC, REHAB Request

Phone: 855-359-9999 Fax: 855-446-9981

Health Plan/ Payor: Care N' Care HMO Care N' Care PPO

Patients 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 Requesting 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.

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