

**INITIAL SKILLED NURSING FACILITY AUTHORIZATION REQUEST FORM**

PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986

Questions? Call 844-411-9622

**FOR FASTER AUTHORIZATION,  
PLEASE VISIT:  
<https://www.mynexuscare.com>**

Date of Request:	<input type="checkbox"/> Standard <input type="checkbox"/> Retro	<input type="checkbox"/> Urgent Request: <i>Note: Expedited organization determinations (urgent requests), can only be requested by the Member, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (see CMS regulation: 40.8)</i>
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<b>Member Information:</b>		
Member Name:	Member ID:	Date of Birth:

Requesting SNF Facility Information	Referral Source Information	
Facility Name:	Referral Source Type: <input type="checkbox"/> Hospital <input type="checkbox"/> SNF <input type="checkbox"/> IRF <input type="checkbox"/> LTACH <input type="checkbox"/> Physician Office	Ordering Physician:
NPI:	<input type="checkbox"/> Emergency Dept <input type="checkbox"/> Psychiatric Hosp/Unit	Ordering Physician NPI:
Phone:	Referral Source:	Date of Onset of Illness/Injury/Exacerbation:
Fax:	Referral Source NPI:	Hospital admission date:
SNF Facility Contact Name:	Referral Source Contact Name:	Anticipated SNF Admit Date:
SNF Facility Contact Phone:	Referral Source Contact Phone:	Is member currently in your facility? <input type="checkbox"/> Y <input type="checkbox"/> N
SNF Facility Contact Fax:		

**Submission MUST include the following as part of your referral package:**

- All pages of this referral form (fully completed – include comments)
- Hospital H & P
- Specialty consultations
- Overall plan of care
- Current medication list/record
- Interdisciplinary Team Assessment (if completed)
- 3 days of most recent physician notes
- 1-2 days of most recent nursing notes
- 1-2 days of most recent wound care notes, if applicable
- Therapist assessment/ current progress notes that provide relevant supplemental information (e.g., cognitive assessment scores, strength/motor recovery information) for PT/OT/ST
- Most recent diagnostics (CT scans / X-ray reports) and lab work

**Please attest to the following: (NOTE: All the following requirements must be met for request to meet medical necessity criteria)**

- The patient is medically stable with medical or surgical comorbidities that do not require ongoing acute medical attention.
- The requested services are directly related to and reasonable in scope and intensity for the referral condition and/or illness.
- There is a reasonable expectation that the requested skilled care is necessary to achieve therapeutic goals.
- Improvement is expected in a reasonable and predictable time period.
- The patient’s condition has reasonable potential to respond favorably to skilled therapies, medical, and/or nursing care.

<b>Admitting ICD-10 Code(s)</b>			
1(Primary)	2	3	4

Clinical Category – Choose 1			
<input type="checkbox"/> Acute Neurologic	<input type="checkbox"/> Wound	<input type="checkbox"/> Major Joint Replacement or Spinal Surgery	<input type="checkbox"/> Other
<input type="checkbox"/> Acute Infections	<input type="checkbox"/> Medical Management	<input type="checkbox"/> Orthopedic Surgery (Except - Major Joint or Spinal Surgery)	<input type="checkbox"/> Unknown
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Cancer	<input type="checkbox"/> Non-Surgical Orthopedic/Musculoskeletal	
<input type="checkbox"/> Pulmonary	<input type="checkbox"/> General weakness/deconditioning	<input type="checkbox"/> Non-Orthopedic Surgery	

*Please answer the following questions:*

Can the needed services be reasonably and safely provided in the home or community?  Yes  No  Unknown

Is there a caregiver identified and able to assist the patient at home?  Yes  No  Unknown

Patient living situation:  Home Alone  Home with Spouse/Family  Supportive Housing  Long Term Care  Homeless  Other  Unknown

Does the patient have a severe mental illness or developmental disability?  Yes  No  Unknown

Does the patient have partial weight bearing or non-weight bearing restrictions?  Yes  No  Unknown

Is the patient cooperative and able to follow 1- 2 step commands?  Yes  No  Unknown

**Documentation of member level of function**

Prior Level of Function?	Current Level of Function?
<input type="checkbox"/> Independent <input type="checkbox"/> Mod Independent <input type="checkbox"/> Sup <input type="checkbox"/> Contact Guard Assist <input type="checkbox"/> Min Assist <input type="checkbox"/> Mod Assist <input type="checkbox"/> Max Assist <input type="checkbox"/> Dependent	<input type="checkbox"/> Independent <input type="checkbox"/> Mod Independent <input type="checkbox"/> Sup <input type="checkbox"/> Contact Guard Assist <input type="checkbox"/> Min Assist <input type="checkbox"/> Mod Assist <input type="checkbox"/> Max Assist <input type="checkbox"/> Dependent

AM-PAC mobility score:  6-7  8-15  16-24  Unknown

**Select all the following skilled services the patient will require for post-acute care.**

<input type="checkbox"/> Medical and/or nursing care	Anticipated Frequency: <input type="checkbox"/> Daily <input type="checkbox"/> Every other day <input type="checkbox"/> Weekly <input type="checkbox"/> Unknown
<input type="checkbox"/> Physical therapy to address functional impairment	Anticipated Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown
<input type="checkbox"/> Occupational therapy to address functional impairment	Anticipated Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown
<input type="checkbox"/> Speech therapy to address functional impairment	Anticipated Frequency: <input type="checkbox"/> 1-2x/wk <input type="checkbox"/> 3-4x/wk <input type="checkbox"/> 5x/wk <input type="checkbox"/> Unknown

**[IF nursing selected above] Does patient require daily skilled nursing for any of the following reasons?**

<input type="checkbox"/> Wound Care	<input type="checkbox"/> Stage III or IV Decubitus Wound(s) <input type="checkbox"/> Other wound(s) that require(s) multiple dressing changes within a 24-hour period
<input type="checkbox"/> Ostomy Care	<input type="checkbox"/> Colostomy care during the early post-operative period ( $\leq$ 14 days from surgery) in the presence of complications is required.
<input type="checkbox"/> Respiratory Care	<input type="checkbox"/> Naso-pharyngeal or deep tracheal suctioning <input type="checkbox"/> Ventilator management and/or weaning <input type="checkbox"/> Nebulizer treatments $\geq$ 2 times/day
<input type="checkbox"/> IV/IM Medications	<input type="checkbox"/> IV medication $\geq$ 2 times/day that patient cannot self-administer. Patient does not have assistance at home, and cannot practically travel to an infusion center <input type="checkbox"/> IM medication $\geq$ 2 times/day and patient cannot self-administer. <input type="checkbox"/> Central line or multiple peripheral IV lines
<input type="checkbox"/> Nutritional Support	<input type="checkbox"/> Initiation of tube feedings $\geq$ 500 ml daily or $\geq$ 26% of daily caloric intake is required. <input type="checkbox"/> Initiation of intravenous (TPN) feeding requires skilled nursing care.
<input type="checkbox"/> Genitourinary (GU) Care	<input type="checkbox"/> Initial clinical management of a urinary catheter (suprapubic or "in and out" catheterization) is required. <input type="checkbox"/> Individual or caregiver requires complex teaching services that can only be delivered in a 24-hour SNF setting and cannot be completed at home.
<input type="checkbox"/> Other	Describe:

**Comment:**

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