myNEXUS

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:	☐ Standard ☐ Retro	☐ Urgent Request: *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)*

Member Information:

Member Name:	Member ID:	Date of Birth:

Requesting SNF Facility Information	*Referral Source Information*	
Facility Name:	Referral Source Type: ☐Hospital ☐SNF ☐IRF ☐LTACH ☐Physician Office ☐Emergency Dept ☐Psychiatric Hosp/Unit	Ordering Physician:
		Ordering Physician NPI:
NPI:		
Tax ID:	Referral Source:	Date of Onset of Illness/Injury/Exacerbation:
Phone:	Referral Source NPI:	Hospital admission date:
Fax:	Referral Source Contact Name:	Anticipated SNF Admit Date:
SNF Facility Contact Name:	Referral Source Contact Phone:	Is member currently in your facility? ☐ Y ☐ N
SNF Facility Contact Phone:		
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.

Admitting ICD-10 Code(s)			
1(Primary)	2	3	4

Clinical Category – Choose 1			
☐ Acute Neurologic	☐ Wound	☐ Major Joint Replacement or Spinal Surgery	☐ Other
☐ Acute Infections	☐ Medical Management	☐ Orthopedic Surgery (Except - Major Joint or Spinal Surgery)	☐ Unknown
☐ Cardiovascular	☐ Cancer	☐ Non-Surgical Orthopedic/Musculoskeletal	
☐ Pulmonary	☐ General weakness/deconditioning	☐ 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?		
☐ Independent	☐ Mod Independent	☐ Sup	☐ Independent	☐ Mod Independent	☐ Sup
☐ Contact Guard Assist	☐ Min Assist	☐ Mod Assist	☐ Contact Guard Assist	☐ Min Assist	☐ Mod Assist
☐ Max Assist	☐ Dependent		☐ Max Assist	☐ 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.	
☐ Medical and/or nursing care	Anticipated Frequency: ☐ Daily ☐ Every other day ☐ Weekly ☐ Unknown
☐ Physical therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown
☐ Occupational therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown
☐ Speech therapy to address functional impairment	Anticipated Frequency: ☐ 1-2x/wk ☐ 3-4x/wk ☐ 5x/wk ☐ Unknown
[IF nursing selected above] Does patient require daily skilled nursing for any of the following reasons?	
☐ Wound Care	☐ Stage III or IV Decubitus Wound(s) ☐ Other wound(s) that require(s) multiple dressing changes within a 24-hour period
☐ Ostomy Care	☐ Colostomy care during the early post-operative period (≤ 14 days from surgery) in the presence of complications is required.
☐ Respiratory Care	☐ Naso-pharyngeal or deep tracheal suctioning ☐ Ventilator management and/or weaning ☐ Nebulizer treatments ≥ 2 times/day
☐ IV/IM Medications	☐ IV medication ≥ 2 times/day that patient cannot self-administer. Patient does not have assistance at home, and cannot practically travel to an infusion center ☐ IM medication ≥ 2 times/day and patient cannot self-administer. ☐ Central line or multiple peripheral IV lines
☐ Nutritional Support	☐ Initiation of tube feedings ≥ 500 ml daily or ≥ 26% of daily caloric intake is required. ☐ Initiation of intravenous (TPN) feeding requires skilled nursing care.
☐ Genitourinary (GU) Care	☐ Initial clinical management of a urinary catheter (suprapubic or "in and out" catheterization) is required. ☐ Individual or caregiver requires complex teaching services that can only be delivered in a 24-hour SNF setting and cannot be completed at home.
☐ Other	Describe:

Comment: