Continued SNF Stay Request for Authorization

Fax completed form to: ***952-853-8712*** *For questions call: 1(888)467-0774*

Submit this form by (certified end date) as well as 2 days prior to end of therapies or discharge date

Patient and Facility Information

Member Name: _____ Facility Name: _____

CoOportunity Health ID#:_____ Facility Contact Name: _____

DOB: _____ Facility Contact Phone: _____

Discharge Date (If Applicable):_____ Facility Fax: _____

Discharge Destination: Home Hospital Nursing Home Other: _____

Physical Restrictions: NO YES (specify) _____

Physical Therapy: Sessions per week ____ Sessions per day ____ Minutes per session _____

Sit/Stand: Dep Max Mod Min CGA S I Endurance: _____

Balance: _____

Pivot/Trfr: Dep Max Mod Min CGA S I ROM: _____

Ambulation: Dep Max Mod Min CGA S I Distance: _____

Current Assistive Device: _____ Pain: _____

Stairs: _____ W/C Mob: _____

Comments: _____

Occupational Therapy: Sessions per week ____ Sessions per day ____ Minutes per session _____

Grm/Hyg: Max Mod Min CGA SBA Sup I Bed Mob: _____

UE Dsg: Max Mod Min CGA SBA Sup I MMSE: _____

LE Dsg: Max Mod Min CGA SBA Sup I IADLs: _____

Toileting: Max Mod Min CGA SBA Sup I

Current Assistive Device: _____ Pain: _____

Comments: _____

Speech Therapy: Sessions per week ____ Sessions per day ____ Minutes per session _____

Communication: _____

Cognitive Linguistic: _____

Swallowing: _____

Comments: _____

Skilled Nursing Interventions:

IV or PICC Line Meds / Flushes: NA QD BID TID Other _____

Description of IV Therapy: _____

G Tube: No Yes Date Initiated: _____ % of nutrition: _____

Wound Care: NA QD BID TID Describe wound treatment: _____

Other Skilled Intervention: _____

Anticipated Date of Completion of Therapy / Treatment Plan: _____