



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:
CoOpportunity 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:

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