HealthPartners®

Skilled Nursing Facility Admission Request Form

Fax completed forms to **(952)853-8712**. Call Utilization Management (UM) at **(952)883-6333** with questions. Incomplete forms will be returned. **Submit hospital d/c summary & plan of care to support skilled cares**. Sign in at healthpartners.com/provider and use the Authorizations and referrals link to check the status of your authorization request.

Member information

First name _____ MI ____ Last name _____

HealthPartners ID # _____ DOB _____

Requester information

Form completed by: First name _____ Last name _____

Your business name _____

Your business street address _____

Your business city _____ Your business state _____ Your business zip _____

Phone* _____ Fax** _____

Attending physician information

Physician first name _____ Physician last name _____

Specialty _____ NPI _____

Clinic name _____

Clinic street address _____

Clinic city _____ Clinic state _____ Clinic zip _____

Clinic tax ID (claim may be rejected if incorrect) _____

Email _____ Phone* _____ Fax** _____

Facility information

Facility name _____

Facility street address _____

Facility city _____ Facility state _____ Facility zip _____

Billing tax ID (claim may be rejected if incorrect) _____ Medicare license # _____

Facility contact name for updates _____

Phone* _____ Fax** _____

Diagnosis information

Primary diagnosis code _____ Description _____

Secondary diagnosis code _____ Description _____

Confidential voicemail required
***For outcome notification*

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Will waiting the standard review time seriously jeopardize member's health, life or ability to regain maximum functioning? ☐ Yes ☐ No

Clinical reason for urgency (not scheduling issues) _____

Medicare covered stay: ☐ Yes ☐ No Days available on admission _____ /100

Actual/Anticipated admit date _____ Actual/Anticipated admit time _____ ☐ AM ☐ PM

Admit from: ☐ Home ☐ Hospital ☐ NH Facility admitted from _____

Reason for admission to SNF _____

Skilled nursing interventions _____

Frequency _____

COVID-19 positive: ☐ Yes ☐ No Symptomatic: ☐ Yes ☐ No Resp. assessment: ☐ QD ☐ BID ☐ TID Other _____

Therapy plan _____ Frequency _____

Anticipated length of treatment _____

Estimated discharge date: _____

Discharge destination: ☐ Home ☐ Home w/ home care ☐ Nursing home ☐ Other (specify) _____

Prior Level of Functioning (PLOF): _____

Home Setting (e.g., single level, apartment, mobile home w/stairs): _____

Number of levels: _____ Number of stairs in prior living environment: _____

Comments _____

Submit hospital d/c summary & plan of care to support skilled cares

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Ongoing Service Review for Skilled Nursing Facility

Fax completed forms to **(952)853-8712**. Call Utilization Management (UM) at **(952)883-6333** with questions. Submit supporting clinical including Discharge Plan, PT/OT/ST, Skilled Nursing notes, treatment plan. Forms that are missing information, have vague or incomplete responses will be returned for additional information or clarification.

Authorization # _____ Reference # _____

Admit date _____ Discharge date (if applicable) _____
Discharge destination: ☐ Home ☐ Home w/ home care ☐ Nursing home ☐ Other (specify) _____
Physical restrictions? ☐ Yes ☐ No If Yes, please explain _____
Anticipated date of completion of therapy / treatment plan _____

Discharge planning

Discharge goal: _____
Home Setting (e.g., single level, apartment, mobile home w/stairs): _____
Number of levels: _____ Number of stairs in prior living environment: _____
Home Evaluation Date: _____
Home Care Agency: _____
Services: _____
Is there a caregiver? ☐ Yes ☐ No If yes, can the caregiver provide the d/c needs? ☐ Yes ☐ No
Barriers to D/C Plan: _____

Physical therapy

Sessions per week _____ Sessions per day _____ Minutes per session _____

Sit/Stand: ◯ Dep ◯ Max ◯ Mod ◯ Min ◯ CGA ◯ S ◯ I
Pivot/Trfr: ☐ Dep ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ S ☐ I
Ambulation: ☐ Dep ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ S ☐ I
Current assistive device _____
Stairs _____
Comments _____

Endurance _____
Balance _____
ROM _____
Distance _____
Pain _____
W/C Mob _____

Occupational therapy

Sessions per week _____ Sessions per day _____ Minutes per session _____

Grm/Hyg: ☐ Dep ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Sup ☐ I
UE Dsg: ☐ Dep ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Sup ☐ I
LE Dsg: ☐ Dep ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Sup ☐ I
Toileting: ☐ Dep ☐ Max ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Sup ☐ I
Current assistive device _____
Comments _____

Bed Mob _____
MMSE _____
IADLS _____
Pain _____

Speech therapy

Sessions per week _____ Sessions per day _____ Minutes per session _____
Communication _____
Cognitive Linguistic _____
Swallowing _____
Comments _____

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Skilled nursing interventions

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

Description of IV Therapy _____

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

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

COVID-19 positive? ☐Yes ☐No Symptomatic? ☐Yes ☐No Resp. Assessment: ○QD ○BID ○TID ○Other _____

List all Skilled Nursing Intervention patient is receiving & frequency _____