

Date: _____
Fax To: (502) 585-8206
ATTN: Long-Term Care Manager/SNF



Skilled Nursing Facility Authorization Form

Note: For timely authorization, items with an asterisk () must be completed.*

*Member's Name: _____

*Member's Passport Advantage ID or SSN: _____

*Date of Admission to SNF: _____

*Primary Diagnosis Code: _____

*Secondary Diagnosis Code: _____

*Ordering Physician (first and last name & telephone number):

_____ (_____) _____ - _____

*Skilled Services Required: _____

Brief Clinical Information to Support Skilled Need:

Please also fax additional clinical notes as needed.

*Requesting Facility Name: _____

Provider ID: _____

Contact's Name: _____

*Facility Telephone: (_____) _____ - _____ *Facility Fax: (_____) _____ - _____

Authorization Number (provided by the Plan, following authorization):

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.