

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