INITIAL SNF STAY
PRIOR AUTHORIZATION FORM

This form must be completed by a person with thorough clinical knowledge of the member's current clinical presentation and his/her clinical evaluation history. **Clinical documentation supporting the medical necessity of this request is required (i.e. hospital: therapy eval(s) / progress notes, admission H&P, documentation of skilled nursing interventions).** For more information, please refer to the medical policy document MC/N002 Skilled Inpatient Services (Skilled Nursing Facility and Acute Inpatient Rehabilitation) located at https://www.preferredone.com/MedicalPolicy/.

Please email this form and clinical documentation to Intake@Preferredone.com or fax to (763) 847-4014.

Member Name	**PreferredOne ID #**	**DOB**
Anticipated Admit Date	**Actual Admit Date**	
PreferredOne Case #	**Facility Confidential Email**	
Physical Restrictions: ☐ **NO** ☐ **YES (specify)**		

Facility Name	**NPI #**
Facility Address	
Facility Contact Name	**Facility Contact Phone**
Confidential Voicemail: ☐ **NO** ☐ **YES**	**Facility Contact Fax**

Ordering Provider (first & last name)	
Ordering Provider NPI #	
Ordering Provider Address	
Ordering Provider Phone	**Ordering Provider Fax**

Admit from: ☐ **HOME** ☐ **HOSPITAL** ☐ **SNF**	**Facility Admitted from**
Diagnosis Codes:	
Reason for SNF Admission:	
Anticipated Treatment Plan (nursing interventions):	
Frequency of Anticipated Treatment(s):	

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Member Name
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*****PLEASE FAX INITIAL SNF THERAPY EVALS TO PREFERREDONE AS SOON AS POSSIBLE*****	
Anticipated Skilled Therapy Plan (PT/OT/ST):	
Frequency of each Anticipated Skilled Therapy:	
Anticipated Discharge Date:	**Anticipated Discharge Disposition:**
Anticipated Discharge Needs:	
Comments:	