500 Exchange Street, Providence, Rhode Island 02903-2699

(401) 459-1000 bcbsri.com

**Skilled Nursing Facility Admission Request Tool**

**For PCP Offices**

Please submit the request for authorization when a physician order is obtained and a bed is SECURED at an accepting skilled nursing facility. For questions during business hours (8 a.m. to 4:30 p.m., Monday through Friday), please call 401-459-1000 extension 3364. If calling after business hours, please call 401-215-6036. Fax all requests to 401-459-1623.

Once the request has been reviewed and a determination has been made the requesting provider, accepting SNF and member will be notified. Member must not be admitted to SNF until BCBSRI provides the authorization number. (Authorization is valid for 72 hours. If the patient is not admitted within that time, a new request must be submitted.)

**Member Information**:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis and Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ordering Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone/contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide alternate contact number/backline if office to close early or if phone to be signed off on early\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What date was the patient last seen by the PCP?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the PCP findings and what is the **reason for the referral?** (Please provide PCP assessment.)

Patient’s level of function in the home? Does the patient live alone?

Does the patient use an assistive device to ambulate? Yes No

Home layout? (ie: single family home, stairs, etc.)

Is the patient receiving home care? Yes No

If so, please provide home care assessment with therapy issues:

**Accepting facility (Patient has a bed reserved pending authorization)**

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom did you speak at the accepting facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of planned admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What qualifies the patient as skilled** -The patient must receive a "skilled" level of care in the nursing facility that cannot be provided at home or on an outpatient basis. Skilled Services require:

* The patient requires these skilled services on a daily basis; and
* As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.
* The services delivered are reasonable and necessary for the treatment of a patient’s illness or injury, i.e., are consistent with the nature and severity of the individual’s illness or injury, the individual’s particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

**Nursing** (Provide clinical information that supports request for skilled nursing care):

**Therapy** (Provide clinical information that supports request for skilled therapy):

Additional information: