Skilled Nursing Facility (SNF)
Referral/Precertification Request Form

NOTE: This form is to be used only for members who are currently admitted in a SNF. For all others, please use the general Referral/Precertification Request Form.

Date of Request: _____

Date of Service: _____

PHP Utilization Management

Phone 720.612.6600 l Fax 303.605.1545

☐ ROUTINE	☐ URGENT*
CMS regulations for processing a Routine request is 14 business days and 72 hours for Part B Medications.	CMS regulations for processing an Urgent request is 72 hours and 24 hours for Part B Medications. Please reserve Urgent requests to those that are medically urgent in nature. ***NOTE: Urgent requests will be given a 10-day authorization only.**

To avoid delays in processing time, please ensure all supportive clinical information is provided with request submission.

Member Info:

Last Name: _____ Insurance ID #: _____

First Name: _____ DOB: _____

Requesting Provider Info:

SNF Where Patient is Currently Admitted: _____

Requesting Provider/Rounding Provider Name: _____

SNF Contact Name: _____ SNF Contact Phone: _____

SNF Contact Fax: _____

Referral/Office Visits to Specialist:

Specialist Practice/Group Name: _____ Specialist Practice/Group NPI: _____

Specialist Physician Name: _____ Specialist Physician NPI: _____

If Out of Network (please select reason):

☐ Network Inadequacy* ☐ Second Opinion* ☐ Other* _____

☐ Patient Request ☐ Continuation of Care**

*Provide/fax clinical documentation to support OON requests **Previous clinicals from specialist required to show need for ongoing care

CPT Code	**1.**	**2.**	**3.**	**4.**
ICD-10 or Diagnosis	**1.**	**2.**	**3.**	**4.**

Number of Visits Requested (6 Maximum): _____

Prior Authorization:

☐ **Imaging/Diagnostics:** _____

(**Denver Only**) Preferred Facilities ☐ Health Images ☐ Invision ☐ Touchstone

Non-preferred Facility* _____ (using other facility may delay determination)

If not Preferred, reason for non-preferred facility: _____

☐ **Procedure:**

☐ Outpatient ☐ Inpatient Procedure Requested: _____

Facility/Provider: _____

CPT Code or Procedure	**1.**	**2.**	**3.**	**4.**
ICD-10 or Diagnosis	**1.**	**2.**	**3.**	**4.**

Provide pertinent clinical information including history, current signs and symptoms, duration, past treatments, results of recent diagnostics or lab, proposed treatment plan. Please attach additional information as needed.

_____

_____

IMPORTANT

To ensure a timely response/determination on your request, please fax all supporting clinicals with request as soon as possible to PHP PA Department at 303-605-1545. This will help facilitate processing of request and decrease unnecessary phone calls.

This referral is not a guarantee of payment. Coverage will be determined based on eligibility and availability of remaining benefits at the time of service.