



Advanced Health
289 LaClair St, Coos Bay, OR 97420
Voice: 541-269-7400 • 800-264-0014
Fax: 541-269-7147 • TTY: 877-769-7400

Skilled Nursing Facility Authorization Request

• For questions call: 541-269-7400 • Fax Completed Form and Records to 541-269-7147•
\*\* PLEASE NOTE: INCOMPLETE FORMS WILL DELAY THE AUTHORIZATION PROCESS \*\*

Member Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Member ID #: \_\_\_\_\_

Facility Referred to: \_\_\_\_\_ Facility NPI#: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Ordering Physician NPI#: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

ICD-10 Code(s) \_\_\_\_\_ (Required field)

TYPE OF REQUEST:

New Admission \_\_\_\_ Admission Date \_\_\_\_\_ Estimated DC Date \_\_\_\_\_

Extension Request \_\_\_\_ # of Additional Days \_\_\_\_ Existing Authorization # \_\_\_\_\_

Treatment Plan (Check all that apply): Skilled Nursing \_\_\_\_ PT \_\_\_\_ OT \_\_\_\_ ST \_\_\_\_ Wound Care \_\_\_\_ IV Abx \_\_\_\_

Additional Information:

Therapies (Please list CPT codes): \_\_\_\_\_

Signature of Requesting Provider: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Disclaimer: Prior Authorization does not assure payment, which also depends on patient eligibility on date of service, contract terms, and compliance with rules, regulations and policies of DMAP, Medicare and DOCS as applicable.