



Skilled Nursing Facility (SNF) Pre-Service Request

Date: _____

Provider Information:

Servicing Provider:

Name: _____
Provider#: _____
NPI#: _____
Address: _____

Phone#:(____)_____
Fax#:(____)_____
Contact Name/Phone#:

Ordering Provider:

Name _____
Provider #: _____
NPI#: _____
Address: _____

Phone#:(____)_____
Fax#:(____)_____
Contact Name/Phone#:

Medicare certified agency: Yes No (other certification) _____

Patient Information:

Patient Name _____
DOB: _____
Member ID#: _____
Address: _____

Subscriber Name: _____
Group#: _____
Secondary Payer Source: Yes No

Diagnosis code(s): _____
3 Day Qualifying Hospitalization: // to //

Skilled Services: SN: __ PT: __ OT: __ ST: __ other: ____ & Frequency: _____

- All the following information is RECOMMENDED to determine medical necessity:**
- * **Medical History**
 - * **Previous Level of Function**
 - * **Initial evaluations**
 - * **Plan of care with measurable goals**
 - * **Progress notes**
 - * **Discharge summary/plan**
 - * **Please fill out provided PT/OT Summary form**

Fax form to: 651-662-1004
Mail form to: Integrated Health Management, PO Box 64668,
St. Paul, Minnesota 55164-0668

PHYSICAL THERAPY SUMMARY

SKILL/TASK (Please indicate level of assistance)	Initial Status/ Evaluation	Week 1	Week 2	Week 3	Week 4	Long Term Goals
Bed Mobility						
Transfers						
<u>Gait:</u> -Distance -Assistive Device:						
<u>Balance</u> -Sitting: -Standing:						

OCCUPATIONAL THERAPY SUMMARY

SKILL/TASK (Please indicate level of assistance)	Initial Status/ Evaluation	Week 1	Week 2	Week 3	Week 4	Long Term Goal
Feeding						
Grooming/Hygiene						
Dressing UB						
Bathing UB						
Dressing LB						
Bathing LB						
ADL Transfers						

Level of Assistance Key:

Max A – Maximum Assistance

Mod A – Moderate Assistance

Min A - Minimal Assistance

Sup - Supervision

Mod I - Modified Independent

I - Independent