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 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's primary health insurance: Advanced Health OHP **Dual Eligible - has Medicare and Advanced HealthOHP**

Member Name: ____ DOB: _____/_____/_____

Member ID #: ___________________

Facility Referred to: ____

Phone #: ___________________________ Fax #: ___________________________

Ordering Physician: ____

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:

Part B Services _______ Member in ICF _____Yes _____ No

Therapies (Please list CPT codes): ____

Requested Visits: _________Visits Per Week for ________ Weeks __________Total Number of Visits

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.

For Internal Use Only:

Contracted Provider: Yes No

Approved as requested

Modified Request:

Approved dates: _____/_____/_____ to _____/_____/_____

MM Staff Signature:____ Faxed via: System: ______ Manual: _________

Date: _____/_____/_____Initials: _____________

Denial Reason ____

Medical Directors Signature (For Denied Services): ____

D PII MC Date: _____/_____/_____NOA Date: ______/______/______ Initials: __________