Skilled Nursing Facility Authorization Form
Fax completed form to: 608-252-0830

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION			
Referring Provider Name (do not list name of hospital as referring provider)			Phone #:
Street Address:			Fax #:
City:	State:		Zip Code:
Provider #:	Tax ID #:	NPI:	Specialty:

REFERRED TO PHYSICIAN/FACILITY/PROVIDER INFORMATION			
Referred To:			Phone #
Street Address:			Fax #
City:	State:		Zip Code:
Provider #:	Tax ID #:	NPI:	Specialty:
Choose SNF or Swing Bed	☐ SNF		☐ Swing Bed

REQUEST INFORMATION			
Requested date of admission to SNF/swing bed:	Diagnosis Code(s):		
Member Admitted From: (e.g., hospital, home)			
3rd party liability. If yes, indicate:	☐ W/C	☐ MVA	☐ Other
Payor Source:	☐ Medicare A Primary	☐ Medica HMO	☐ Medica PPO/POS
Other/Comments			

Form Submitted By:		
Name:	Phone:	Fax:

For further information on skilled nursing facilities, please see the Medica medical policy Skilled Nursing Facility.

The completed form can be faxed to: 608-252-0830.
If you have any questions regarding the services or form, please contact Member Services at the number on the member's ID card. or review the Medical Management page. Requests to non-plan providers must be approved prior to obtaining services.