

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 FACILITY/PROVIDER			
Referred To:			Phone #
Street Address:			Fax #
City:	State:	Zip Code:	
Provider #:	Tax ID #:	NPI:	Specialty:
Choose SNF or Swing Bed		<input type="checkbox"/> SNF	<input type="checkbox"/> Swing Bed

REQUEST INFORMATION	
Requested date of admission to SNF/Swing bed:	Diagnosis Code(s):
Member Admitted From: (e.g. hospital, home)	
3 <sup>rd</sup> party liability? If yes, indicate:	<input type="checkbox"/> W/C <input type="checkbox"/> MVA <input type="checkbox"/> Other
Payor Source:	<input type="checkbox"/> Medicare A Primary <input type="checkbox"/> Prevea360 HMO <input type="checkbox"/> Prevea360 PPO/POS
If payor source is Medicare A, how many SNF days have been used previously in this benefit period?	
Other/Comments:	

Form Submitted By:		
Name:	Phone:	Fax:

For further information on skilled nursing facilities, please see the Prevea360 Health Plan medical policy [Skilled Nursing Facility MP9310](#).

Prevea360 Health Plan products are underwritten by Dean Health Plan.  
 If you have any questions regarding the services or form, please contact our Customer Care Center at 877-230-7555 or review [Prevea360 Health Plan's Medical Management](#) site.  
 Requests to non-plan providers must be approved prior to obtaining services.