Skilled Nursing Facility

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 #:		

REFERRED TO FACILITY/PROVIDER		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
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	☐ Prevea360 HMO	☐ 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.

Underwritten by Dean Health Plan, Inc.
If you have any questions regarding the services or form, please contact Customer Service 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.
Updated: 09/2020