ASURIS NORTHWEST HEALTH

Pre-authorization Request Form
Skilled nursing (SNF), Long Term Acute Care (LTAC), Inpatient Rehabilitation (IP Rehab)
Fax: 1 (855) 848-8220
Mail to: PO Box 1271, WW5-53
Portland, OR 97207-1271

Instructions: This form should be completed and filled out by the requesting provider. Prior to completing this form, please confirm the patient's benefits, eligibility and whether pre-authorization is required.

Expedited request. I attest that this request meets the definition indicated below by checking the expedited request box. ☐ Fax to 1 (855) 240-6498.

Expedited is defined as: When the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

SECTION 1 – PATIENT INFORMATION																			
Patient Name (Last)					First										MI	Patient's Phone #			
Patient's Asuris Member ID #										Group #									Date of Birth

SECTION 2 – PROVIDER INFORMATION									
Requesting/Prescribing Provider Name					Tax ID #				
NPI #	Office Phone #				Confidential Voice Mail ☐ Yes ☐ No			Fax #	
Mailing Address					City			State	ZIP Code
Provider Specialty					Email Address				
Who should we contact if we require additional information?									
Name	Phone # Ext.				Confidential Voice Mail ☐ Yes ☐ No			Fax #	
If a physician reviewer needs a peer to peer discussion before a determination, please provide the treating provider's direct phone number and availability for the next 3 to 5 days.									
Phone #: Ext:	Date: Time:				Date: Time:			Date: Time:	
Facility Name					Tax ID #			NPI #	
Mailing Address					Fax #				
City	State	ZIP Code			Phone # Ext.			Confidential Voice Mail ☐ Yes ☐ No	
Email Address					**Note:** This form does not serve as a notification of admission. Please reference our provider website for instructions about how to notify us of an admission.				

SECTION 3 – PREAUTHORIZATION REQUEST

Date of Admission _____

Transfer from another facility? ☐ Yes ☐ No If Yes, Facility Name: _____

Skilled Services Needed:	
Level of Function/Cognition:	Current:
	Prior:
Ambulatory Ability:	
Social Support: Lives	☐ Alone ☐ w/son/daughter ☐ w/ spouse ☐ w/ other _____

Please provide all diagnosis and their descriptions.

Diagnosis code(s) and description(s)	
Primary:	
Second:	
Third:	

SECTION 4 – DOCUMENTATION SUBMISSION

Submit the following documentation, as appropriate, with this request:

Specific clinical information documenting the applicable MCG™ or Medicare medical necessity criteria, **including:**

- History and physical
- PT/OT/SLP assessment and current notes within past 48 hours, as applicable
- Current symptoms and functional impairments
- Treatment history and any other information, such as chart notes that support medical necessity for the request.
- Physician Progress Notes from the past 48 hours

Any other supporting documents you would like considered, such as letters from outpatient providers, etc.