

# Skilled Nursing Admission Notification Form

Submit completed form via fax to Health Services at 1-833-263-4865 or email SNF@MediGold.com.

## Member Information

Date: \_\_\_\_\_

Member's Name	Member's ID
Skilled Nursing Facility (SNF)	
TIN Number	NPI Number
SNF Phone Number	SNF Fax Number
Requesting Provider (if different than SNF)	Requesting TIN Number
Requesting NPI Number	Name of Person Completing Request
Contact Phone Number	Contact Fax
Admit Date	IC-10 Code(s)

## Skilled Services being requested:

- |  |   |
|--|---|
| <input type="checkbox"/> Physical Therapy        | <input type="checkbox"/> Ventilator                 |
| <input type="checkbox"/> Occupational Therapy    | <input type="checkbox"/> Trach Care                 |
| <input type="checkbox"/> Speech Therapy          | <input type="checkbox"/> IV Antibiotics             |
| <input type="checkbox"/> Complex Wound Care      | <input type="checkbox"/> Tube Feeding (NG, NJ, PEG) |
| <input type="checkbox"/> IV Nutrition (TPN, PPN) | <input type="checkbox"/> Chemotherapy or Radiation  |

Please supply clinical documentation to support the medical necessity of each service selected.

## Ambulation/Mobility:

Distance ft x	Assistive Device
Balance <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	Gait <input type="checkbox"/> Steady <input type="checkbox"/> Unsteady

## Cognition:

Alert & Oriented <input type="checkbox"/> Yes <input type="checkbox"/> No	Unable to follow instructions: <input type="checkbox"/> Yes <input type="checkbox"/> No
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**ADL Activities:** Answer Independent, CGA, Min Assist, Max Assist x1 or Max Assist x2 for each ADL.

Bed Mobility	Transfers
Toileting	Eating

<b>Member's Name</b>	<b>Member's ID</b>
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**Rehab Potential**  
 **Good**    **Fair**    **Poor**

**Prior Level of Function**

**DC Living Environment**

**Any Additional Information**

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