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:

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Complex Wound Care
- ☐ IV Nutrition (TPN, PPN)
- ☐ Ventilator
- ☐ Trach Care
- ☐ IV Antibiotics
- ☐ Tube Feeding (NG, NJ, PEG)
- ☐ Chemotherapy or Radiation

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

Ambulation/Mobility:

Distance ft x	**Assistive Device**
Balance ☐ Good ☐ Fair ☐ Poor	**Gait** ☐ Steady ☐ Unsteady

Cognition:

Alert & Oriented ☐ Yes ☐ No	**Unable to follow instructions:** ☐ Yes ☐ No

ADL Activities: Answer Independent, CGA, Min Assist, Max Assist x1 or Max Assist x2 for each ADL.

Bed Mobility	**Transfers**
Toileting	**Eating**

Member's Name	**Member's ID**

Rehab Potential
☐ **Good** ☐ **Fair** ☐ **Poor**

Prior Level of Function

DC Living Environment

Any Additional Information