SAMARITAN HEALTH PLANS • INTERCOMMUNITY HEALTH NETWORK CCO • 2300 NW WALNUT BLVD. • CORVALLIS, OR 97330

SNF/LTAC/ACUTE REHAB – AUTHORIZATION REQUEST

IMPORTANT!
Illegible/incomplete requests will be sent back for clarification and completion. All requests for authorization must be complete and include all information necessary to make decisions in a timely manner.

FAX FORM(S) TO: SHP Utilization Management
541-359-4064

For Internal Use Only:

For assistance with completing this form, please call 541-768-5207 or 1-888-435-2396

❑ Standard ❑ Expedited ❑ Retro request	Date:
Medical documentation **required** if referral is to be **EXPEDITED** MD Sign*: _____	* Signature indicates waiting for a decision within standard time frame could place a member's life, health, or ability to regain maximum function in serious jeopardy.

CHECK HEALTH PLAN (ONE ONLY)

❑ Samaritan Advantage ❑ Samaritan Choice ❑ IHN-CCO ❑ Commercial

PATIENT INFORMATION

Last Name:	First Name:	MI:

Patient's Primary Care Provider:	Date of Birth:	Health Plan ID#:

REFERRAL INFORMATION

ICD Code:	Planned Date of Admission: ❑ To Be Scheduled
Requesting Provider Name (First, Last):	PAR Provider: ❑ Yes ❑ No

Contact Person:	Phone:	Fax:

REFERRAL TYPE

❑ Skilled Nursing Facility ❑ LTAC ❑ Acute In-Patient Rehab	Out of Area Facility NPI:

Facility Name:	Phone:	Fax:

Facility Address:

REASON FOR REQUEST / COMMENTS / ADDITIONAL DETAILS (E.G. "DAY TREATMENT", DATE SPAN/FREQUENCY)

REMINDER: Form must be complete and must include supporting documentation.