

CUSTODIAL LONG TERM CARE (LTC) SERVICES REQUEST FORM



Fax: 1(415) 943-9700 Telephone: 1(415) 615-4583

NOTE: ALL FIELDS MARKED WITH AN ASTERISK (*) ARE REQUIRED.

TYPED ONLY - NO HANDWRITTEN FORMS

Select type of request*: New Custodial Care Request Reauthorization of Custodial Care, Auth #:
 Other Medical Services or DME Equipment Bed Hold/LOA

Select response time of request*: Urgent Routine Retro (Must be submitted within 30 calendar days of the date of service)

Definition of Urgent: when the member's condition is such that the member faces an imminent and serious threat to their health and a routine timeframe could jeopardize their ability to regain maximum function, and/or could lead to the potential loss of life, limb, or other major bodily function. Requests outside of this definition should be submitted as routine/non-urgent.

Authorizations are based on medical necessity and covered services. Authorizations are contingent upon member's eligibility and benefits and are not a guarantee of payment. The provider is responsible for verifying member's eligibility on the date of service. Please verify eligibility using one of the following methods:

1. Web: sfhp.org/providers 2. Interactive Voice Response: 1(415) 547-7810 3. SFHP Customer Services: 1(800) 288-5555

Select line of business: Medi-Cal ****Note:** Custodial Long Term Care Requests are not a Healthy Workers HMO Covered Benefit

Does additional coverage exist?* Yes No **If yes, specify the following:** Carrier: _____ Policy #: _____

PATIENT		RENDERING PROVIDER	
Name*:		Name of Facility*:	
SFHP ID#*:	Date of Birth*:	NPI #*:	
Telephone:		Telephone:	
Address:		Contact Name:	Fax*:
		Address:	

GENERAL CONDITION		ADMITTED FROM	
<input type="checkbox"/> Bedridden	<input type="checkbox"/> Maximum Assistance with all ADL's	<input type="checkbox"/> Home	<input type="checkbox"/> Board & Care/Assisted Living
<input type="checkbox"/> Ambulatory with Assistance	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Acute Hospital	<input type="checkbox"/> Step down from Skilled
<input type="checkbox"/> Incontinent of B&B	<input type="checkbox"/> Confined to Wheelchair	<input type="checkbox"/> Another SNF	<input type="checkbox"/> Homeless

DIAGNOSE/ICD-10 CODES	NEW MEDICATION OR TREATMENT ORDERS (EXCLUDING PRN)				
At least one valid diagnosis code is required.*	Medication/Treatment	Dose	Frequency	Route	Description
Diagnosis Code(s):					

SERVICE CODES: If no quantity is indicated, the amount will default to 1. Ensure quantities are consistent with valid CPT/HCPCS/REV codes.

CODE	MOD	QTY	DESCRIPTION	CODE	MOD	QTY	DESCRIPTION

Date & Time of Request: _____ Comments: _____

Important: Please attach current Health & Physical and appropriate supporting medical records for timely review.