LONG-TERM CARE (LTC) SERVICES REQUEST FORM

SAN FRANCISCO HEALTH PLAN™

Fax: **1(415) 943-9700** Telephone: **1(415) 615-4530**

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

TYPED ONLY - NO HANDWRITTEN FORMS

Select type of request*: | Initial Request | Reauthorization, Auth #:
☐ Other Medical Services or DME Equipment ☐ Bed Hold/LOA; Start Date

Facility/Level of Care: | SNF | ICF-DD | SUB-ACUTE

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: 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**	
☐ Bedridden	☐ Maximum Assistance with all ADLs	☐ Home	☐ Board & Care/Assisted Living
☐ Ambulatory with Assistance	☐ Ambulatory	☐ Acute Hospital	☐ Step down from Skilled
☐ Incontinent of B&B	☐ Confined to Wheelchair	☐ Another SNF	☐ Homeless

DIAGNOSE/ICD-10 CODES

At least one valid diagnosis code is required.*
Diagnosis Code(s):

NEW MEDICATION OR TREATMENT ORDERS (EXCLUDING PRN)

Medication/Treatment	Dose	Frequency	Route	Description

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.