

FYI: Please submit this form to Aspirus upon preadmission, admission, discharge and whenever there is an update or change within 24 hours. *Incomplete, illegible or inaccurate forms will be returned to the sender.* Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of the request. Review our provider manual criteria references. **Include the following:** Admission Assessment, therapy evaluations/ notes, discharge summary and copy of NONMC or NDMC if applicable.

For questions call: 715.631.7412 or 1.855.931.4851

Fax form and relevant clinical documentation for Admissions and Concurrent Review to: **715.787.7316**

Email: clsintakeMA@aspirushealthplan.com

PREADMISSION / ADMISSION:		<input type="checkbox"/> Skilled Nursing Home	<input type="checkbox"/> Swing Bed
<input type="checkbox"/> Preadmission			<input type="checkbox"/> Concurrent
<input type="checkbox"/> Admission			Today's Date:
Date of Admission:			Expected Date of Admission:

PATIENT INFORMATION:			
Name:			
Date of Birth:		Member ID:	
Address:			
City:		State:	Zip Code:
Phone:			
Member Product (required)*:			

ADMITTING FROM FACILITY INFORMATION:			
Admission from:		<input type="checkbox"/> Community	<input type="checkbox"/> Hospital
		<input type="checkbox"/> Lives in Nursing Home	
Hospital Admission Date:		Hospital Discharge Date:	
Name of Hospital:			
Primary Admission Diagnosis (ICD-10) Code:			

ADMITTING TO FACILITY INFORMATION:		<input type="checkbox"/> CONTRACTED	<input type="checkbox"/> NON-CONTRACTED
Facility Name:		Facility NPI # (required)*:	
Address:			
Phone:			

CONTACT PERSON FOR QUESTIONS:			
<input type="checkbox"/> Admitting Facility		<input type="checkbox"/> Ordering Facility	
Name:			
Phone:		Fax:	
Email:			
Preferred Method of Contact:		<input type="checkbox"/> Phone	<input type="checkbox"/> Fax
		<input type="checkbox"/> Email	

REASON FOR AUTHORIZATION REQUEST (SELECT ONE):		
<input type="checkbox"/> Authorization/ Notification Request		
<input type="checkbox"/> Benefit Exception:		
<input type="checkbox"/> Out of Network Provider Requesting Network Exception		
Admission/ Change/ Update/ Discharge:	Effective Date of Change/ Update:	Reason Codes:

REASON CODES:	
1. Preadmission	6. Hospice (non-covered)
2. Initial Admission	7. Readmission (Hospital back to SNF)
3. Discharge (Home)	8. Transfer from another SNF
4. Discharge (Hospital)	9. Other Healthcare Facility
5. Discharge (Death)	10. Change in Medicare qualified stay/end of benefit (last covered day)