SKILLED NURSING HOME/SWING BED ADMISSION NOTIFICATION FORM

Reset Form

FYI: Please submit this form to Aspirus Health Plan upon 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

Send form and relevant clinical documentation for Admissions and Concurrent Review to:

Fax : 715.787.7316

Email: clsintakeMA@aspirushealthplan.com

ADMISSION: ☐ INITIAL ☐ CONCURRENT	
☐ Skilled Nursing Home	☐ Swing Bed
Member Admitted to Facility ☐Yes ☐No	
Today's Date:	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:	◯ Community	◯ Hospital	◯ Lives in Nursing Home
Hospital Admission Date:		Hospital Discharge Date:	
Name of Hospital:			
Primary Admission Diagnosis (ICD-10) Code:			

ADMITTING TO FACILITY INFORMATION: ☐ CONTRACTED ☐ NON-CONTRACTED	
Facility Name:	Facility NPI # (required)*:
Address:	
Phone:	

CONTACT PERSON FOR QUESTIONS:			
☐ Admitting Facility		☐ Ordering Facility	
Name:			
Phone:		Fax:	
Email:			
Preferred Method of Contact:	◯ Phone	◯ Fax	◯ Email

REASON FOR AUTHORIZATION REQUEST (SELECT ONE):
☐ Authorization/ Notification Request
☐ Benefit Exception:
☐ Out of Network Provider Requesting Network Exception

Admission/ Change/ Update/ Discharge:	Effective Date of Change/ Update:	Reason Codes:

REASON CODES:	
1. Initial Admission	6. Readmission (Hospital back to SNF)
2. Discharge (Home)	7. Transfer from another SNF
3. Discharge (Hospital)	8. Other Healthcare Facility
4. Discharge (Death)	9. Change in Medicare qualified stay/ End of benefit (Last covered day)
5. Hospice (Noncovered)	10. Other, please specify