HEALTH TRADITION

Fax the completed form and clinical information to:
Health Tradition Health Plan UM Department
Fax Number: 608.781.9654
Urgent Fax: 608.467.4964

65+ Skilled Nursing Facility/Notification Form

Supporting clinical documentation, including any progress notes must accompany this form.

All fields are required. Incomplete or illegible information will be returned and not processed.

MEMBER INFORMATION

Patient Name (First, MI, Last)		Date of Birth	Insurance ID#	
Gender	Admission Date	Expected Discharge Date	LOS	Authorization Number (if known)

FACILITY INFORMATION

Facility and NPI #		Doctor's Name or Ordering Provider
UR Phone Number	Contact Name	Sender's Fax Number

☐ MEDICARE A (qualifying stay) - Submit clinical including discharge paperwork.

Diagnosis	Start Date
Expected End Date	Exact End Date

☐ REQUEST FOR ADDITIONAL 30 DAYS - Submit recent evaluation PT/OT/SLP and nursing note and hospital notes if any.

Diagnosis	Start Date
Therapies Needed	Concerns

☐ MEDICARE B (qualifying stay) - Submit clinical including discharge paperwork.

Diagnosis	Start Date
Expected End Date	Exact End Date