



CONCURRENT AUTHORIZATION REQUEST SNP | SIP | IRF | LTACH

Submit this completed form by fax to **1-833-610-2399**, or on our provider portal:
<https://secure.healthx.com/KeyCareAdvantage.Provider>
 Call 1-844-206-1205 (TTY 711) to speak with a representative.

Members must be referred to in-network facilities and providers unless emergent, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

Routine/Standard Serious jeopardy to the member's life or health or ability to regain maximum function

| MEMBER INFORMATION | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------|
| Member Name: | Member ID: | |
| Date of Birth: | Authorization number: | |
| CURRENT LEVEL OF CARE | | |
| <input type="checkbox"/> SNF | <input type="checkbox"/> Inpatient Rehab | <input type="checkbox"/> LTACH |
| CM/SW Name: | Phone Number: | Fax Number: |
| Prior Living Conditions: <input type="checkbox"/> Independent <input type="checkbox"/> Lives with others <input type="checkbox"/> SNF <input type="checkbox"/> ALF/ILF | | |
| Owned DME: <input type="checkbox"/> Cane (SP/Quad) <input type="checkbox"/> Walker <input type="checkbox"/> Rollator <input type="checkbox"/> W/C <input type="checkbox"/> Power w/c or Scooter <input type="checkbox"/> BSC <input type="checkbox"/> Other: | | |
| BRIEF CURRENT MEDICAL STATUS UPDATE | | |
| Provide brief update on member status/diagnosis/medical condition (If there is a decline, please state reason): | | |
| Wound Location, size: | Wound treatment/dressing type and frequency: | |
| IV Antibiotics: please include name/frequency/duration: | | |
| Name: _____ Frequency: _____ Duration: _____ | | |
| Name: _____ Frequency: _____ Duration: _____ | | |
| Name: _____ Frequency: _____ Duration: _____ | | |
| PT Updates Bed mobility: Transfers: Ambulation: | OT Updates Feeding: Bathing: Dressing: Toileting: | ST Updates: Language/Expression: Cognition: Diet: |



Anticipated Discharge Date:

D/C Barriers:

CLINICAL INFORMATION

- Clinical/ therapy documentation/ assessments should be within 72 hours of request.
- Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.
- Missing this information may delay the decision on your request or may result in Lack of Information denial.

Provider Attestation: By signing below, I certify that the patient’s medical records accurately reflect the information provided. I understand that KeyCare Advantage may request medical records for this patient at any time in order to verify this information. I further understand that if KeyCare Advantage determines this information is not reflected in the patient’s medical records, KeyCare Advantage may request a refund of any payments made and/or any other remedies available.

Please certify the following by signing and dating below:

Provider Signature: _____ **Date:** _____

Please fax form to: 1-833-610-2399