THE OHIO STATE UNIVERSITY
HEALTH PLAN

AUTHORIZATION FORM FOR ADMISSION TO SKILLED NURSING FACILITY OR LONG-TERM ACUTE CARE HOSPITAL

Instructions: Please print all requested information and submit this form to OSU Health Plan via email at**:** UtilizationManagement.OSUHealthPlan@osumc.edu or fax to: **614-292-2667.** Contact your OSU Health Plan UM Case Manager at 614-292-4700 should you have questions or require assistance in completing the entire form.

PATIENT INFORMATION: PRINT all information requested below:

First Name: _____Last Name: _____ DOB:___/___/_____

Insurance ID #: _____ Diagnosis: _____ICD-10_____; _____

To be transferred/discharged from: _____ Planned admission on: ___/___/____

ADMITTING FACILITY INFORMATION: PRINT all information requested below:

Complete Name:_____ Telephone Number: (____)_____-_____

Admissions Contact Name: _____ Telephone Number: (____)_____-_____ext_____

Fax Number: (____)_____-_____ Email Address:_____

Additional Comments:

_____

_____

IF LOA (LETTER OF AGREEMENT) IS NEEDED FROM OSU HEALTH PLAN, PROVIDER RELATIONS, PLEASE PROVIDE: PRINT all information requested below:

Mailing Street Address: _____ City: _____

State: _____ Zip: _____ TAX ID # _____ NPI# _____

TO BE COMPLETED BY OSU HEALTH PLAN

Level of Care: ☐ ECF ☐ SNF 1 ☐ SNF 2 ☐ SNF 3 ☐ SNF 4

Authorization # _____

☐ Approved for Dates: _____ Next Review Date: _____

☐ Denied – Reason: _____

Any additional comments: _____

Case Manager Name: _____ Telephone Number: (____) _____-_____

Email Address: _____

SNFAUTH09.2018