# Skilled Nursing Facility (SNF)/Long-Term Care (LTC) Custodial – Authorization Request Form (ARF)
## *(for SNF/LTC/Subacute/Hospice Room and Board)*

The Alameda Alliance for Health (Alliance) Skilled Nursing Facility (SNF)/Long-Term Care (LTC) Custodial – Authorization Request Form (ARF) (*for SNF/LTC/Subacute/Hospice Room and Board)* is confidential. Filling out this form will help us better serve our members.

**INSTRUCTIONS**

1. Complete all the fields below by printing clearly or typing.
2. Include the following attachments:
    a. Verification of Alliance eligibility
    b. Physician order with physician signature
    c. Documentation to support the level of care requested: (Minimum Data Set (MDS) 3.0 [LTC], and notes related to discharge planning)
3. For SNF requests, please fax the completed form to the Alliance Inpatient Team at **1.855.313.6306**.
4. For LTC/Subacute/Hospice Room and Board requests, please fax the completed form to the Alliance Long-Term Care (LTC) Department at **1.510.747.4191**.

**PLEASE NOTE:** Incomplete forms may be delayed or declined and returned to the referral source. Authorization does not guarantee payment. The Alliance reserves the right to request additional documentation as needed to make a determination. Alliance eligibility must be verified at the time the services are rendered.

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**SECTION 1: MEMBER INFORMATION**

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Age: _____

Language: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ ☐ Home ☐ Cell

Alliance Member ID #: _____ Client Identification Number (CIN): _____

Aid Code: _____ County Code: _____

Primary Insurance: _____ Secondary Insurance: _____

## SECTION 2: TYPE OF REQUEST

Please select only one (1):

- ☐ Routine – Initial
- ☐ Routine – Re-Authorization/Concurrent Review Authorization #: _____
- ☐ Urgent (members being discharged from the hospital)
- ☐ Retro
- ☐ Modification Alliance Authorization #: _____

## SECTION 3: MEDICARE/BENEFIT STATUS

Medicare Status: _____

Benefit Status (please select only one (1)):

- ☐ Benefits exhausted:
  - Date Medicare Benefits Exhausted (MM/DD/YYYY): _____
  - Dual Eligible Special Needs Plan (D-SNP)
  - Please attach the Notice of Medicare Non-Coverage (NOMNC)
- ☐ Benefits **NOT** exhausted
  - Number of Medicare Days Available: _____
  - Other Dual Eligible Special Needs Plans (D-SNP)

## SECTION 4: LEVEL OF CARE REQUESTED

Requested Start Date: _____ Requested End Date: _____

Please select only one (1):

- ☐ Skilled 1
- ☐ Skilled 2
- ☐ Skilled 3
- ☐ Skilled 4
- ☐ Bed Hold (Maximum of 7 days) (if selected, please include MD orders for the transfer **and** bed hold)
- ☐ Leave of Absence (Maximum of 18 days per calendar year)
- ☐ Hospice Room and Board
- ☐ NF-A (Custodial)
- ☐ NF-B (Custodial)
- ☐ Sub-Acute (Non-Vent) LOS Day 0-30
- ☐ Sub-Acute (Non-Vent) LOS Day >30
- ☐ Sub-Acute (Vent) LOS Day 0-30
- ☐ Sub-Acute (Vent) LOS Day >30

Member Last Name: _____ Member First Name: _____ CIN: _____

## SECTION 5: PROVIDER INFORMATION

Facility Name: _____

Facility Contact Last Name: _____ Facility Contact First Name: _____

Facility Address: _____

City: _____ State: _____ Zip Code: _____

Facility Phone Number: _____ Facility Fax Number: _____

Physician Last Name: _____ Physician First Name: _____

Physician Phone Number: _____ Physician Fax Number: _____

Diagnosis/Diagnoses: _____

ICD Codes: _____

## SECTION 6: ADMISSION SOURCE/REFERRAL INFORMATION

Please select only one (1):

- ☐ Acute Hospital
- ☐ Board & Care/Assisted Living
- ☐ Emergency Room
- ☐ Home
- ☐ Transitioning from Skilled to Custodial Level of Care
- ☐ Other: _____

Date of LTC Placement Referral: _____

Community Options Available: ☐ Yes ☐ No

Reason for LTC SNF Placement: _____

## SECTION 7: MEMBER'S GENERAL CONDITION

Please select all that apply:

- ☐ Ambulatory
- ☐ Ambulatory with assistance
- ☐ Confined to bed
- ☐ Incontinent of bowel and bladder
- ☐ Maximum assistance with all ADLs
- ☐ Wheelchair confined

## SECTION 8: REFERRING PROVIDER INFORMATION

Last Name: _____ First Name: _____

Additional Comments:

Member Last Name: _____ Member First Name: _____ CIN: _____