Vaya Health

Post-Acute Facility Service Authorization Request Form

Use this form to request prior authorization of skilled nursing facility (SNF), sub-acute rehabilitation, acute rehabilitation, and long-term acute care hospital (LTACH) services if you are unable to access Vaya Health's (Vaya's) Provider Portal. When possible, Vaya strongly prefers service authorization requests (SARs) be submitted through the portal.

Submission Requirements

- Fax completed forms to 828-759-2161.
- Do not combine forms and records for multiple patients in one fax. Per Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, send separate faxes for each patient.
- Allow 48-72 hours for processing of admission and continued stay requests:
  - Initial admissions review requests must be accompanied by supporting medical records, including physical and occupational therapy (PT and OT) evaluations and treatment plans.
  - Continued stay review requests must be accompanied by supporting medical records, including PT and OT documentation completed 24-48 hours prior to the requested dates of service.

DO NOT USE THIS FORM FOR:	INSTEAD:
Home health care service requests	Use the Physical Health Outpatient SAR Form on our Prior Authorization webpage
Radiology, cardiology, durable medical equipment (DME), and outpatient specialized therapy requests (e.g., physical therapy, occupational therapy)	Contact eviCore healthcare at 1-800-918-8924 ext. 24176 or www.evicore.com/provider

All requests must be accompanied by supporting medical records, including physicians' orders, notes, test results, etc. Failure to provide complete information and required medical records will result in authorization delays. For more information, visit the Authorization Guidelines page on Vaya's Provider Central website.

Member Information

Last name: _____ First name: _____

Medicaid ID #: _____ Date of birth: _____

Pre-Admission Screening and Resident Review (PASRR) #: _____

Authorization Request Information

Date of request: _____

Admitting from: Select _____ Admitting to: Select _____

Provider/facility requesting this authorization: _____

Contact name: _____ Phone: _____

Email: _____ Fax: _____

Post-Acute Facility Information:

Admitting facility name: _____

Facility address: _____

Facility TIN: _____ Facility NPI: _____

Network status: ☐ Network provider ☐ Out-of-network provider

Contact name: _____ Phone: _____

Email: _____ Fax: _____

Admission Information

Admission date: _____ Diagnosis code: _____

Description: _____

Did the patient have a procedure that precipitated admission? ☐ Yes ☐ No

If yes, describe _____

Date of procedure (if applicable): _____ Estimated length of stay: _____

Is the patient cognitively able and actively willing to participate in therapy services? ☐ Yes ☐ No

Patient Medical History

Describe prior level of functioning (PLOF):

_____

Neurological

Cognition: ☐ A&O X (specify #) _____

☐ Other If "other," specify: _____

Gastrointestinal/genitourinary

Bowel: ☐ Continent ☐ Incontinent Ostomy: ☐ Yes ☐ No

Bladder: ☐ Continent ☐ Incontinent Catheter: ☐ Yes ☐ No

Respiratory

Oxygen: ☐ Yes ☐ No If "yes," specify: Type: _____ Flow rate: _____ Saturation: _____

Vent: ☐ Yes ☐ No If "yes," specify: Saturation: _____ Settings: _____

Trach: ☐ Yes ☐ No If "yes," specify: Type: _____

Suctioning: ☐ Yes ☐ No If "yes," specify: Frequency: _____

Respiratory treatments: ☐ Yes ☐ No If "yes," specify: Frequency: _____

Integumentary

☐ Skin is intact ☐ Skin is not intact (provide details below)

Provide details for each wound or lesion below.

1. Wound details:

   Current size (L x W x D): _____ Initial size (L x W x D), if different: _____

   Location: _____ Stage: _____

   Treatment (type and frequency): _____

2. Wound details:

   Current size (L x W x D): _____ Initial size (L x W x D), if different: _____

   Location: _____ Stage: _____

   Treatment (type and frequency): _____

3. Wound details:

   Current size (L x W x D): _____ Initial size (L x W x D), if different: _____

   Location: _____ Stage: _____

   Treatment (type and frequency): _____

4. Wound details:

   Current size (L x W x D): _____ Initial size (L x W x D), if different: _____

   Location: _____ Stage: _____

   Treatment (type and frequency): _____

5. Wound details:

   Current size (L x W x D): _____ Initial size (L x W x D), if different: _____

   Location: _____ Stage: _____

   Treatment (type and frequency): _____

Medications/nutrition:

IV Therapy: ☐ Yes ☐ No Diet: _____

Tube feeding: ☐ Yes ☐ No Total parenteral nutrition (TPN): ☐ Yes ☐ No

Therapy (Describe the member's current level of functioning.)

Physical therapy (PT):

Bed mobility: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

Transfers: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

Gait: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

Gait Distance: _____ Gait Assistive Device: ☐ None Type: _____

Stairs: Current number of stairs patient can climb: _____

Stairs: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

Occupational therapy (OT):

Bathing UE: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

Bathing LE: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

Dressing UE: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

Dressing LE: _____ Gait Assistive Device: ☐ None Type: _____

Toileting/hygiene management: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

ADL Transfers: ☐ Total ☐ Max A ☐ Mod A ☐ Min A ☐ CGA ☐ SBA ☐ Mod ☐ Ind

Comments/goals:

Speech therapy:

No speech therapy needed

Dysphagia: ☐ Yes ☐ No

Cognitive deficit: ☐ Yes ☐ No

Dysarthria: ☐ Yes ☐ No

Comments/goals:

Discharge planning (Must begin at admission)

Discharge date: _____ Discharge location: _____

Home evaluation date: _____ Discharge barriers: _____

Additional information (optional):