



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: _____

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):