

Today's Date: \_\_\_\_\_

This form is for Long-Term Care level of care authorization. Please complete and fax to SCFHP Utilization Management (UM) department at **1-408-376-3548**. If you have any questions please call the UM department at **1-408-874-1821**.

Member Name: \_\_\_\_\_ SCFHP ID: \_\_\_\_\_

Member Date of Birth (DOB): \_\_\_\_\_

Line of Business:  Medi-Cal  Cal MediConnect

Member Original Admit Date: \_\_\_\_\_

Diagnosis Codes: \_\_\_\_\_

Requested Service Dates: (MM/DD/YYYY)

From \_\_\_\_\_ to: \_\_\_\_\_

Type of Long Term Care Request:

 Initial Routine Re-Authorization Routine Initial Retro Re-Authorization Retro

Type of Contract:

 Subacute Vent Subacute Non Vent Level of Care Change

Referring Provider Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Servicing Nursing Facility Name: \_\_\_\_\_

Servicing Facility Fax Number: \_\_\_\_\_

Nursing Facility Contact Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**REQUIRED DOCUMENTATION: Submission of all attachments is required for authorization approval:**

- Face Sheet
- Care Plan (Treatment Plan, Discharge Plan, etc.)
- Medicare Denial Letter (if applicable)
- Physician's Current Orders, Signed and Dated

**Note:** Please refer to Long Term Care Authorization Form FAQs for additional details.