Santa Clara Family Health Plan™

Long Term Care Authorization Form

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 <u>all attachments is required</u> 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.