Santa Clara Family Health Plan™

Long-Term Care Authorization Form

Utilization Management
Phone: **1-408-874-1821**
Fax: **1-408-376-3548**
Email: UMHelpDesk@scfhp.com

Today's date: ____

This form is for long-term care level of care authorization. Please complete and fax to Santa Clara Family Health Plan (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** or refer to the Long-Term Care Authorization Form FAQs for additional details.

Member name: ____ **SCFHP ID:** __________________

Member date of birth: ______________________________________

Line of business: ☐ Medi-Cal ☐ DualConnect

Member admission date (current stay): ____

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: ____

NPI#: _______________________________

Phone:_______________________________ **Fax:** ____

Servicing nursing facility name:____

NPI#: _______________________________

Phone:_______________________________ **Fax:** ____

Contact name:____

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