



CONCURRENT AUTHORIZATION REQUEST FORM

SNP | SIP | IRF | LTACH

<p>Submit this completed form by fax to 1-833-610-2399, or on our provider portal: https://secure.healthx.com/AlignSeniorCare.Provider Call California: 1-844-305-3879 (TTY 711), Florida: 1-844-788-8935 (TTY 711), Michigan: 1-855-855-0336 (TTY 711) to speak with a representative.</p>

Members must be referred to in-network facilities and providers unless emergent, other exclusions may apply. Authorized services are not a guarantee of payment. Payment is only authorized for medical services noted below and is subject to the limitations and exclusions as outlined in the Member Handbook/ Certification of Coverage. All requests are reviewed for medical necessity. Incomplete submissions may result in processing delays. Information must be legible.

☐ Routine/Standard ☐ Serious jeopardy to the member's life or health or ability to regain maximum function

MEMBER INFORMATION		
Member Name:		Member ID:
Date of Birth:	Authorization number:	
CURRENT LEVEL OF CARE		
<input type="checkbox"/> SNF	<input type="checkbox"/> Inpatient Rehab	<input type="checkbox"/> LTACH
CM/SW Name:	Phone Number:	Fax Number:
Prior Living Conditions: <input type="checkbox"/> Independent <input type="checkbox"/> Lives with others <input type="checkbox"/> SNF <input type="checkbox"/> ALF/ILF		
Owned DME: <input type="checkbox"/> Cane (SP/Quad) <input type="checkbox"/> Walker <input type="checkbox"/> Rollator <input type="checkbox"/> W/C <input type="checkbox"/> Power w/c or Scooter <input type="checkbox"/> BSC <input type="checkbox"/> Other:		
BRIEF CURRENT MEDICAL STATUS UPDATE		
Provide brief update on member status/diagnosis/medical condition (If there is a decline, please state reason):		
Wound Location, size:		Wound treatment/dressing type and frequency:
IV Antibiotics: please include name/frequency/duration:		
Name: _____ Frequency: _____ Duration: _____		
Name: _____ Frequency: _____ Duration: _____		
Name: _____ Frequency: _____ Duration: _____		
PT Updates Bed mobility: Transfers: Ambulation:	OT Updates Feeding: Bathing: Dressing: Toileting:	ST Updates: Language/Expression: Cognition: Diet:



Anticipated Discharge Date:
D/C Barriers:
CLINICAL INFORMATION
<ul style="list-style-type: none">• Clinical/ therapy documentation/ assessments should be within 72 hours of request.• Documents to attach (where applicable): History and Physical, Discharge Summary, Therapy Progress Notes, Medication list, etc.• Missing this information may delay the decision on your request or may result in Lack of Information denial.

Provider Attestation: By signing below, I certify that the patient’s medical records accurately reflect the information provided. I understand that Align Senior Care may request medical records for this patient at any time in order to verify this information. I further understand that if Align Senior Care determines this information is not reflected in the patient’s medical records, Align Senior Care may request a refund of any payments made and/or any other remedies available.

Please certify the following by signing and dating below:

Provider Signature: _____ **Date:** _____

Please fax form to: 1-833-610-2399