



Concurrent Review Authorization Form

For Concurrent Review Requests: Fax to 877.791.4098 or call 866.220.3071 to speak with an eviCore representative.

Please provide supporting clinical documentation when applicable.
Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable. Preauthorization and authorization for continued stays are not a guarantee of payment.

Disclaimer statements and attestation

- Verify eligibility and benefits prior to request. SNF/LTAC or IRF benefits verified? Yes No
If "yes", number of days available _____
- Is the admission a result of a motor-vehicle accident or workplace injury? Yes No
- Are all therapy notes within 24-48 hours of admission date? Yes No
- SNF member is receiving at least one hour of therapy five days a week? (choose only one answer) Yes No
- Has this member started receiving services for this request? Yes No
- Has this member already been discharged from this service? Yes No

Sign and date here: _____

Documents to Attach: History & Physical Discharge Summary (if available) Clinical Progress Notes (for recertification requests)
Medication list Therapy notes including level of participation (evaluation and last progress notes within the last 24-48 hours)

Assessment Type

Facility Type Requesting:	SNF _____ SNF Level	IRF	LTAC	Estimated Length of Stay (# of days)
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Member/Facility Information

Member Name	Date of Birth	Member Address		
Policy Number	Member Phone Number		PAC Facility Admission Date	
Servicing Facility Name	Servicing Facility Address			
Servicing Facility Phone	Servicing Facility Contact Name		Servicing Facility NPI	

Member Information

Primary Caregiver	Contact Number	Child	Spouse	Friend	Self
		Paid caregiver			
Residence Prior to Admission to Hospital:	Lives alone	Lives with family	Lives with paid caregiver	Homeless	Shelter
		Assisted living facility Long term care/NH			

Admission Information

Admitting Doctor	Admitting Doctor Address/Phone Number
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Along with this form, please submit the following (if applicable) with your precertification request. Any missing required information could result in an unnecessary delay or potential denial:

- Total minutes of therapy per week (please indicate minutes here) _____
- Total minutes of therapy per day (please indicate minutes here) _____
- Prior and current level of functioning _____
- PT/OT/ST evaluations/progress notes **within the last 24-48 hours**
 - Ambulation: # of feet /Assist device used
 - Ability to perform ADL's
 - Bed Mobility
 - Transfers
 - Toileting transfers
 - Gait/Distance
- Home evaluation: Number of steps at home/level of assistance needed
- Wound details: Wound size, location, treatments
- Complete Medication List
- Discharge Plan/Barriers