FirstChoice VIP CARE®
by Select Health of South Carolina

Prior Authorization Form
Skilled Nursing Facilities

Fax completed form to 1-833-512-1700.

Patient name:

Date of birth: Date of admission: Plan ID number: Benefit days: _____ /100

Facility name: Phone number: Fax:

Facility case manager:

Diagnosis:

History of admission or synopsis:

Past medical history:

Social history:

Prior level of function:

Discharge plan:

Barriers to discharge:

Medical review

	Date	Date	Date	Date	Date	Date	Notes
Orientation							
Vital signs							
Respiration							
Oxygen saturation (O_2 sats)							
Tracheostomy (trach)							
Ventilator (vent)							
Nebulizer (nebs)							
Bilevel positive airway pressure (BiPAP)							
Tube feedings							

Rehabilitation

	Goals	Current	Date	Date	Date	Date	Notes
Gait		Distance: Assistive device: Level of assistance:					
Stairs							
Bed mobility							
Transfers		Sitting: Standing:					
Feedings							
Grooming							
Bathing		Upper body: Lower body:					
Toilet		Transfer: Hygiene:					
Cues							
Balance							
Strength							
Tolerance							
Home management							
Speech							

Notes:

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