care n care
Insurance Company, Inc.

# Silverback Care Management
# SNF, LTAC, REHAB Request

**Phone:** 855-359-9999 **Fax:** 855-446-9981

**Health Plan/Payor:** ❑ Care N' Care PPO ❑ Care N' Care HMO

**Patient's Current Location (If Facility, name of Facility is Needed):**

❑ ER: _____ ❑ Acute: _____ ❑ LTAC/REHAB:_____
❑ Office ❑ Home ❑ Other:_____

| Request for: | ❑ SNF | ❑ LTAC | ❑ REHAB | Today's Date: |
|---|---|---|---|---|
| Patient's Name: | | DOB | | Member ID: |
| Patient PCP: | | | | NPI: |
| Requestor Name: | | | | |
| Requestor Phone: | | | | FAX: |

| Expected Admit Date: | |
|---|---|
| Ordering Physician: | Ordering Physician NPI: |
| Facility: | Facility NPI: |
| Treating Physician: | Treating Physician NPI: |

| ICD-10 CM Diagnosis Description | ICD-10 CM Code |
|---|---|
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| Describe any special circumstances which should be considered when authorizing services: | |
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| Clinical Information: ****Clinical Information MUST be included with Request including eval and clinical notes from referring facility**** | |
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☐ **FOR EXPEDITED REQUESTS ONLY.** Check is requesting an expedited review that meets CMS definition that determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Please allow 48 hours for a response. Authorization does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitation, provisions and exclusions.