THE OHIO STATE UNIVERSITY
HEALTH PLAN

AUTHORIZATION FORM FOR ADMISSION TO SKILLED NURSING FACILITY OR LONG-TERM ACUTE CARE HOSPITAL

Instructions: Please print all requested information and submit this form to OSU Health Plan via email at **:** UtilizationManagement.OSUHealthPlan@osumc.edu or fax to: **614-292-2667.** Contact your OSU Health Plan UM Case Manager at 614-292-4700 should you have questions or require assistance in completing the entire form. Please note: The turnaround time for OSUHP authorization process is one business day.

PATIENT INFORMATION: PRINT all information requested below:

First Name:_____Last Name:_____DOB:___/___/_____

Insurance ID #:_____Diagnosis:_____ICD-10_____;_____

To be transferred/discharged from:_____Planned admission on:___/___/____

ADMITTING FACILITY INFORMATION: PRINT all information requested below:

Complete Name:_____Telephone Number: (____)_____-_____

Admissions Contact Name:_____Telephone Number: (____)_____-_____ext_____

Fax Number: (____)_____-_____Email Address:_____

Additional Comments:

_____

_____

IF LOA (LETTER OF AGREEMENT) IS NEEDED FROM OSU HEALTH PLAN, PROVIDER RELATIONS, PLEASE PROVIDE: PRINT all information requested below:

Mailing Street Address:_____City: _____

State:_____Zip:_____TAX ID #_____NPI# _____

TO BE COMPLETED BY OSU HEALTH PLAN

Level of Care ☐ ECF/SNF 1 ☐ SNF 2 ☐ SNF 3 ☐ SNF 4 ☐ LTAC

Authorization # _____

☐ Approved for Dates:_____ Next Review Date: _____

☐ Denied – Reason: _____

Any additional comments: _____

Case Manager Name:_____RN____Telephone Number: (____)_____-_____

Email Address: _____