



**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: _____