Post-Acute Authorization Request

For Family Care Partnership Program Members ONLY

Please complete this form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, phone: 262-207-9393, please call UM with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	DOB:	Medicare #:
		Medicaid #:

Current Setting/Hospital Stay			
Location:			
Admit Date:			
Admitting Diagnosis:			
Inpatient/Observation status: NOTE: CCI follows the Medicare rule requiring a 3-day qualifying inpatient hospitalization			
Requesting/Servicing Provider Information			
☐IRF	☐LTAC	☐TBI	SNF☐ (Medicare A stay only) For all other SNF level of care authorizations please call 1-866-937-2783 and ask for the member care team.
Requesting Facility Name: Address:			
Tax ID:		NPI #:	
Whom should CCI contact with approval to admit?	Name:	Phone:	Fax:
Whom should CCI contact at facility for ongoing clinical updates?	Name:	Phone:	Fax:
ICD 10 Diagnosis and Code.			
Anticipated Admission Date:			
Estimated Length of Stay:			

Initial POC goals including supporting clinical documentation, please attach.