

Skilled Nursing Facility Update Form

Submit completed form via fax to Health Services at 1-833-263-4865 or email SNF@MediGold.com. Include your most recent clinical notes with this form.

Member Information

Date: _____

Member's Name	Member's ID
Skilled Nursing Facility (SNF)	Patient Date of Birth
TIN Number	NPI Number
SNF Phone Number	SNF Fax Number
Attending Physician	SNF Contact Person
Contact Phone Number	Contact Fax Number
Admit Date	Est. DC Date
Discharge Plan (including living environment, DME)	

Continued Skilled Services being requested:

- | | |
|--|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Ventilator |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Trach Care |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> IV Antibiotics |
| <input type="checkbox"/> Complex Wound Care | <input type="checkbox"/> Tube Feeding (NG, NJ, PEG) |
| <input type="checkbox"/> IV Nutrition (TPN, PPN) | <input type="checkbox"/> Chemotherapy or Radiation |

Please supply clinical documentation to support the medical necessity of each service selected.

Additional information to support stay

Recent Fall or Acute Process. If yes, explain:

- Yes No

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