Fax

CareFirst Medicare Advantage

POST-ACUTE CARE AUTHORIZATION FORM	
To: Post-acute Care Unit	From:
Fax: - 410-505-2588	Office Phone:
	Cell Phone:
Date:	Number of pages: *(including cover sheet)*

Dear Provider,

Please complete all fields below and include all current (within past 24-48 hours) PT/OT/ST or pertinent clinical information for the requested service.

This is a concurrent request, a decision will be completed and communicated within 1 business day once all required information is received. This form is to be used for Medicare Advantage members only.

Member Name		CareFirst ID Number
Current Location of the Member		
Requested Level of Care (i.e. Hospice, SNF level (1-4), Acute Rehab, LTAC)		
Receiving Facility		
Date of Admission to Receiving Facility and NPI number		
Primary Diagnosis/ICD10		
Attending Physician (Current or at Facility) and NPI number		
Contact information for Receiving Facility (Name)		Phone
Address of Receiving Facility		
City	State	Zip Code

Confidentiality Notice

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