Fax

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)

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

Confidentiality Notice

Unauthorized interception of this communication could be a violation of Federal and State Law.This communication and any files transmitted with it are confidential and may contain protected health information.This communication is solely for the use of the person or entity to which it was intended. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies. Thank you.