



Date of Request

UPHP SKILLED NURSING FACILITY AND SWING BED NOTIFICATION AND INFORMATION FORM

Fax completed form to 906-225-9269 as directed below.

FACILITY NAME _____ FACILITY CONTACT _____

PATIENT NAME _____ ADMISSION DATE _____

DOB _____ ID# _____

DIAGNOSIS _____

TYPE OF SKILLED SERVICE:

- PT/OT/ST
- Wound care
- IV therapy
- TPN
- OTHER _____

FREQUENCY OF THERAPY/TREATMENT: _____

IS PATIENT PARTICIPATING IN THERAPY? Yes _____ No _____

If no explain: _____

BARRIERS TO DISCHARGE:

- Housing
- Caregiver
- Home safety
- Transportation
- OTHER _____

IS LONG TERM CARE PLACEMENT ANTICIPATED? Yes _____ No _____

ESTIMATED DISCHARGE DATE: _____

ACTUAL DISCHARGE DATE: _____

Please fax updates every 7 days to 906-225-9269 on all UPHP skilled care patients:
QUESTIONS? Call 906-225-7774

UPHP STAFF ONLY	
Authorization# _____	UPHP Staff _____
Effective Start Date _____	Next Update Due _____
Notification does not guarantee payment	
All services are subject to review for medical necessity, member eligibility, and plan benefits at time of service	