



Request Submission Date _____

UPHP NURSING FACILITY AND SWING BED NOTIFICATION AND INFORMATION FORM

Please submit the form to us via the UPHP Clinical Submission Form on our website at www.uphp.com/ClinicalSubmissionForm/. UPHP will send a fax response to the Contact Fax number entered below once the notification has been processed.

Facility Name: _____

Facility Contact Name: _____ Contact Phone: _____

Contact Fax: _____

UPHP Member/Patient Name: _____ Date of Birth: _____

ID Number: _____

ADMIT TO:

Skilled Care OR **New** Long-Term Care Current Start Of Care Date: _____

Diagnosis With Codes: _____

Type of Skilled Service:

PT/OT/ST
Wound Care
IV Therapy
TPN
Other _____

Barriers To Discharge:

Housing
Transportation
Home Safety
Caregiver
Other _____

Frequency Of Therapy/Treatment: _____

Is Patient Participating In Therapy? Yes No If No, Explain: _____

Estimated Discharge Date: _____ Actual Discharge Date: _____

Is Patient **Returning** To Long Term Care At Same Facility? Yes No

Please send us updates for all UPHP skilled care patients. You can submit updates and discharge notifications to us via the UPHP Clinical Submission Form on our website: www.uphp.com/ClinicalSubmissionForm/

Questions? UPHP Clinical Services - Utilization Management (UM) Team Direct Line: 906-225-7774

UPHP STAFF ONLY	
Authorization ID: _____	Effective Start Date: _____
UPHP Staff: _____	Next Update Due: _____
ON ADMIT	
Skilled Days Available _____	Last Covered/Billable Day _____
Skilled Days Used Upon Discharge _____	Skilled Days Remaining Upon Discharge _____
<p>Notification does not guarantee payment. All services are subject to review for medical necessity, member eligibility, and plan benefits at time of service.</p>	