

PATIENT DEMOGRAPHICS		
Patient Name:		Date of Birth:
Member ID:		Phone Number:
Street Address:		
City:	State:	Zip Code:

REFERRING PROVIDER INFORMATION		
Referring Provider Name (do not list name of hospital as referring provider):		Phone #:
Street Address:		Fax #:
City:	State:	Zip Code:
Provider #:		

REFERRED TO FACILITY/PROVIDER		
Referred To:		Phone #
Street Address:		Fax #
City:	State:	Zip Code:
Choose SNF or Swing Bed	SNF	Swing Bed

REQUEST INFORMATION			
Requested date of admission to SNF/Swing bed:		Diagnosis Code(s):	
Member Admitted From: (e.g. hospital, home)			
3 rd party liability? If yes, indicate:		W/C	MVA
			Other
Payor Source:	Medicare A primary	MAPD	
	DeanCare Gold/Select	Check here if requesting a 30 day Mandate	
	Dean HMO	Dean PPO/POS	BadgerCare Other (describe) _____
If payor source is Medicare A, how many SNF days have been used previously in this benefit period?			
Other/Comments:			

Form Submitted By:		
Name:	Phone:	Fax:

For further information on skilled nursing facilities, please see the Dean Health Plan medical policy [MP9310 Skilled Nursing Facility](#).

The completed form can be faxed to: 608-252-0864.

If you have any questions regarding the services or form, please contact our Customer Care Center at 877-234-4516 or review [Dean Health Plan's ASO Medical Management](#) site.

Requests to non-plan providers must be approved prior to obtaining services.