DeanHealthPlan
A member of SSM Health

Skilled Nursing Facility Fax
completed form to: 608-252-0830

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)				
3rd 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: 608-252-0830.

If you have any questions regarding the services or form, please contact our Customer Care Center at 800-279-1301 or review Dean Health Plan's Medical Management site. Requests to non-plan providers must be approved prior to obtaining services.