DeanHealthPlan by Medica

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 #:	Tax ID #:	NPI:	Specialty:

REFERRED TO FACILITY/PROVIDER			
Referred To:			Phone #
Street Address:			Fax #
City:	State:		Zip Code:
Provider #:	Tax ID #:	NPI:	Specialty:
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.