Skilled Nursing Facility Update Form

Submit completed form via fax to Health Services at 1-833-263-4865 or email SNF@MediGold.com. Include your most recent clincial notes with this form.

Member Information

Date:_____

Member's Name	**Member's ID**
Skilled Nursing Facility (SNF)	**Patient Date of Birth**
TIN Number	**NPI Number**
SNF Phone Number	**SNF Fax Number**
Attending Physician	**SNF Contact Person**
Contact Phone Number	**Contact Fax Number**
Admit Date	**Est. DC Date**

Discharge Plan (incluing living environment, DME)

Continued Skilled Services being requested:

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Complex Wound Care
- ☐ IV Nutrition (TPN, PPN)
- ☐ Ventilator
- ☐ Trach Care
- ☐ IV Antibiotics
- ☐ Tube Feeding (NG, NJ, PEG)
- ☐ Chemotherapy or Radiation

Please supply clinical documentation to support the medical necessity of each service selected.

Additional information to support stay

Recent Fall or Acute Process. If yes, explain:

☐ **Yes** ☐ **No**