



## Skilled Nursing Facility Admission Request Form

Fax completed forms to (952)853-8712. Call Utilization Management (UM) at (952)883-6333 with questions. Incomplete forms will be returned. [Submit hospital d/c summary & plan of care to support skilled cares.](#)

### Member information

First Name MI Last Name  
HealthPartners ID # DOB

### Requester information

Form completed by: First Name Last Name  
Your business name  
Your business street address  
Your business city Your business state Your business zip  
Phone\* Fax\*\*

### Attending physician information

Physician first name Physician last name  
Specialty NPI  
Clinic name  
Clinic street address  
Clinic city Clinic state Clinic zip  
Clinic tax ID (claim may be rejected if incorrect)  
Email Phone\* Fax\*\*

### Facility information

Facility name  
Facility street address  
Facility City Facility state Facility zip  
Billing tax ID (claim may be rejected if incorrect)  
Facility contact name for updates  
Phone\* Fax\*\*

### Diagnosis information

Primary diagnosis code Description  
Secondary diagnosis code Description

\*Confidential voicemail required

\*\*For outcome notification

