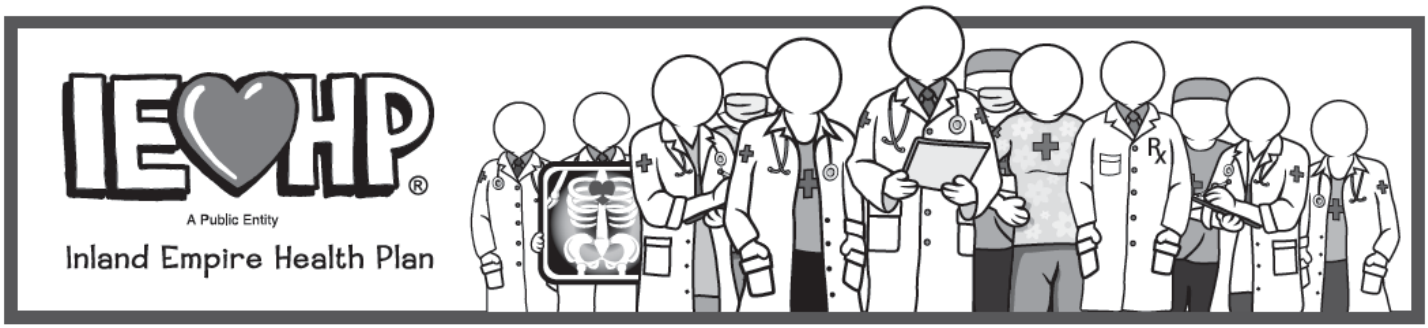

To: Skilled Nursing Facilities

From: IEHP – Provider Relations

Date: July 24, 2020

Subject: **REVISED Service Request Form for Post-Acute Facilities**

Effective immediately, Inland Empire Health Plan (IEHP) requires that all Post-Acute Facilities utilize the attached **Revised Service Request Form** when requesting any services that are not included in the per diem reimbursement for IEHP Members.

For example, the form would be used to request:

- Durable Medical Equipment (DME) for Members at a **Skilled** level of care.
- Specialty Physician consults or Rehab Therapy for Members in **Custodial** level of care.

To confirm if a specific service will require the Service Request Form, please consult your IEHP Nurse Case Manager.

The completed form can be emailed to the IEHP Nurse Case Manager or Coordinator assigned to each facility or faxed to **(909) 912-1045**.

For your convenience, an electronic copy of the Revised Service Request Form is available on our Provider Portal at: www.iehp.org > For Providers > Provider Resources > Forms > UM/CM.

As a reminder, all communications sent by IEHP can also be found on our Provider portal at: www.iehp.org > For Providers > Plan Updates > Correspondence.

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.

Enclosure: Revised Service Request Form

INLAND EMPIRE HEALTH PLAN

SERVICE REQUEST FORM FOR SKILLED NURSING FACILITIES

REQUEST URGENCY (PLEASE SELECT ONE)

- ☐ Standard Request
- ☐ Expedited Request (requires justification documented below or will revert to Standard)
  - ☐ Member's life is in serious jeopardy
  - ☐ Member's health is in serious jeopardy
  - ☐ Member's ability to regain maximum function is in serious jeopardy
  - ☐ Member discharging within 24 hours

REQUEST INFORMATION

Request Date: _____ **Requested By:** _____

Requesting Provider: _____

Phone: _____ **Fax:** _____

Member Name: _____ **DOB:** _____

IEHP Member ID: **Expected Discharge:**

REQUESTED SERVICES

PLEASE SUBMIT ONLY ONE (1) SERVICE REQUEST PER FORM

Requested Service: _____

CPT/Procedure Code(s): Please contact Provider office to obtain correct procedure codes

CPT #1: _____ **CPT #4:** _____

CPT #2: _____ **CPT #5:** _____

CPT #3: _____ **CPT #6:** _____

ICD/Diagnosis Code(s): Please provide diagnosis codes pertaining to this request

ICD #1: **ICD #2:**

SERVICING PROVIDER INFORMATION

Provider Name: _____ **NPI:** _____

Provider Address: _____

Phone: _____ **Fax:** _____

Contact Person: **Confirmed?** ☐ Yes ☐ No

***** FORM REQUIREMENTS *****

Complete Service Request Form in its entirety.

Attach clinical notes, signed MD orders, and supporting documents.

Fax Service Request Form and supporting all documents to (909) 912-1045.

Please Note: request will be delayed if any required information is missing.