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.