naviHealth Authorization Initiation Form

naviHealth

Intake

Requestor Name: ______________________________ Phone: ______________________________

Fax: ______________________________

Level of Care:

Request Priority:

Anticipated Discharge Date: ______________________________

Provider Details

Requesting Facility Name: ______________________________

Requesting Facility Address:

Street: ______________________________

City: ______________________________

Requesting Facility NPI: ______________________________

Ordering Acute Physician: ______________________________ ______________________________

Ordering Acute Physician NPI (if available): ______________________________

Name of Post-Acute Facility member is discharging to : ______________________________

Address of Post- Acute Facility (if available):

Street: ______________________________

City: ______________________________

Additional Authorization Comments:

Document Check List

These are the documents needed to complete this authorization:

- ☐ Hospital Face Sheet
- ☐ History & Physical Document
- ☐ Therapy Evaluations (within previous 48 hours)
  - ☐ Prior Living Situation
  - ☐ Current Cognitive Status
  - ☐ Prior Level of Function
- ☐ Therapy Notes (within previous 24-48 hours)
- ☐ Physician Notes (within previous 24 hours)
- ☐ Physician Orders Sheet / Medication List
- ☐ Post-procedure Notes
- ☐ Nursing Admission Assessment

Disclaimer: Authorization is based on the information provided, it is not a guarantee of payment. Billed services are subject to medical necessity, appropriate setting, billing/coding, plan limits, eligibility at time of service. Verify benefits online or call Customer Service.