Inland Empire Health Plan

Service Request for Skilled Nursing Facilities

Please check one:	
☐ Standard Request	☐ Expedited Request

Date: _____

Member's Information:		
Last:	First:	ID#:

Requesting Provider's Information:		
Name:	Phone:	Fax:

Servicing Provider's Information:		
Name:	NPI:	
Address:	ZIP:	State:
City:	Phone:	Fax:

Requested Service:

ICD / Diagnosis Code(s): (Pertaining to Requesting Services)	
1.	2.

CPT / Procedure Code(s): (Please call Provider's office to obtain correct codes)	
1.	4.
2.	5.
3.	6.

Special Instructions/Comments:

Note: To expedite approval/denial, please fill in all areas completely and attach all needed documents, please attach the **MD order, facesheet, and any other pertinent information related to services requested**. Fax all documents to IEHP's LTC Department at **(909) 912-1045**. Please contact IEHP LTC Case Manager or Coordinator assigned to your facility with any questions or concerns. Thank you.

Revised: 08/2018