



**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: _____
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SERVICING PROVIDER INFORMATION

Provider Name: _____	NPI: _____
Provider Address: _____	
Phone: _____	Fax: _____
Contact Person: _____	Confirmed? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Complete Service Request Form in its entirety.

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

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

Any request for Hospice authorization or Hospice services should be faxed to (909) 297-2513