Valor Health Plan

Insurance focused on you.

**Skilled Services Authorization Request Form: Please send to your Valor NP or Case Manager**

This authorization is NOT a guarantee of eligibility or payment. Any services rendered beyond those authorized or outside approval dates will be subject to denial of payment.

Authorization Type: (check one) ☐ Standard ☐ Expedited

____/____/____ *Check here if request is in response to a denied claim* ☐

Member Name: _____

Member Number: **VL**_____ Date of Birth: ____/____/____

Prescribing Provider: _____

Servicing Provider/Facility Name: _____

Phone: _____ Fax: _____

**Request Service: Skilled Services** **Service Dates:** _____

Nursing Services being completed under skilled time:

_____

_____

_____

_____

_____

Skilled Therapy Needs:

☐ Physical Therapy # of visits per week _____

☐ Occupational Therapy # of visits per week _____

☐ Speech Therapy # of visits per week _____

ICD_____ Diagnosis Descriptions _____

☐ **Clinicals are attached to support request. (All applicable clinicals should be attached.)**

**Concurrent Review Request: (Please submit at least 2 days prior to expiration of current approval)**

Description of continued need of skilled services (nursing and/or therapy):_____

_____

_____

_____

_____

☐ **Skilled nursing documentation attached to support continued skilled nursing needs and/or updated therapy notes**

**NOMNC is the responsibility of the facility to provide to member. Valor accepts the traditional CMS NOMNC:**

QIO: Livanta 888-524-9900

Plan Contact Information: Valor Health Plan Customer Service 1-800-485-3793

NOMNC must be issued 2 days prior to last covered day. Payment is not guaranteed for unapproved extension due to failure to provide NOMNC timely.

For Questions Regarding this Request, Contact:

Name: _____

Phone: _____ Fax: _____

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