



LTC Fax Cover Sheet – Fax to 888-687-2515

Facility Name:		Point of Contact:	
Date Faxed:	Phone:	Fax:	Pages Included:

☐ Referral to Long Term Care: <u>Requested Level of Care (Please select one):</u> ☐ MHRC/STP ☐ CO-SNF ☐ SNF Patch ☐ NBU Patch ☐ State Hospital ☐ Long Term Care Referral Screening Form ☐ Required documents for requested level of care ☐ Long Term Care Exception Request Form (if applicable) ☐ Additional requested documents	☐ Continued Authorization Request: <u>Requested Level of Care (Please select one):</u> ☐ MHRC/STP ☐ CO-SNF ☐ SNF Patch ☐ NBU Patch ☐ Other: <u>Requested Start Date:</u> ☐ SNFs: Concurrent Review Form ☐ Required documents for requested level of care ☐ Long Term Care Exception Request Form (if applicable) ☐ Additional requested documents
☐ Administrative Day Request: <u>Requested Level of Care:</u> ☐ MHRC/STP with County paying bed day ☐ CO-SNF <u>Requested Start Date:</u> ☐ Long Term Care Administrative Day Request Form ☐ Required documents for requested level of care ☐ Additional requested documents	☐ Other:

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