align
powered by
SANFORD HEALTH PLAN

Post Acute Prior Authorization Request

Date _____

Member information

Member name (print)		SHP ID	Date of birth (m/d/y)
List the patient's diagnosis/condition			

Referring provider information

Referring provider name (print)		Specialty	Telephone number
Referring provider address			
Contact person, if more information is needed	Title	Telephone number	Fax number

Rendering provider information

☐ Same as referring provider

Rendering provider name (print)		Specialty	Telephone number
Rendering provider address			
Provider NPI		Provider tax ID	

Place of service

☐ Long Term Acute Care (LTAC) ☐ Inpatient Rehabilitation (IPR) ☐ Swing Bed

☐ Skilled Nursing Facility (SNF) ☐ Other _____

Facility where services will be provided (include address if the provider provides services at more than one practice location)

Provide supportive documentation for this prior authorization request.

_____ _____
Provider signature   Date

Submit this completed form via:

- Portal at https://www.securityhealth.org/providers; or
- Fax to 715.221.9215

If you have questions, contact Post Acute Care Customer Service at 715-221-9212.