



**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:** _____

SERVICING PROVIDER INFORMATION

Provider Name: _____ **NPI:** _____

Provider Address: _____

Phone: _____ **Fax:** _____

Contact Person: _____ **Confirmed?** Yes No

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

Complete Service Request Form in its entirety.

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

Fax Service Request Form and supporting all documents to (909) 912-1045.

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