Blue Cross Blue Shield of Michigan

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Skilled Nursing Facility, Acute Inpatient Rehabilitation Facility Fax Assessment Form

☐ Re-sending fax
☐ Precertification
☐ Recertification

Complete this form and fax to: 1-866-411-2573
UAW Retiree Contracts fax to: 1-866-915-9811

Facility and provider must participate with local Blue Cross Blue Shield plan or member may incur higher costs. Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable. Precertifications and Recertifications are not guarantee of payment.

Incomplete or illegible submissions will be returned unprocessed.

Disclaimer Statements and Attestation

- **Please allow 24-48 hours for processing precertification and recertification requests.**
- Please verify eligibility and benefits prior to request. SNF/Rehab benefits Verified ☐ No ☐ Yes. Yes, number of days available____.
- All therapy notes are within 24 to 48 hours of admission date or last covered date (only choose one answer) ☐ Yes ☐ No
- SNF member is receiving at least 1 hour of therapy 5 days a week (only choose one answer) ☐ Yes ☐ No
- Acute rehab member is receiving OT or PT at least 3 hours per day, 5 days per week and able to sit for 1 hour a day (only choose one answer) ☐ Yes ☐ No

Assessment type/coverage

Facility type: ☐ SNF ☐ Acute Inpatient Rehabilitation | Number of days requested: ☐ 7 days ☐ 10 days ☐ 14 days | **ELOS** (# of days)

Member/facility information

Member name	Date of birth	Address	
Policy number	Member phone number	Hospital	Admission date
Admitting facility and NPI number	Facility PIN number	Phone number	Facility reviewer name
Fax number	Address		

Admission Information

Admission date to SNF/IPR	Admitting doctor (first/last name and NPI#)
Physician address/phone number	
Hospital admitting diagnosis and ICD-10 CM code	
Complications	
Surgical procedure	Date
Medical history	
Height / **Weight**	**Prior level of function (home)**

Mobility current functioning

Date of PT/OT notes:

Focus goal of physical therapy

Bed mobility:	☐ Total assist	☐ Max assist	☐ Mod	☐ Min
	☐ CGA	☐ SBA	☐ Mod Ind	☐ Ind
Transfers:	☐ Total assist	☐ Max assist	☐ Mod	☐ Min
	☐ CGA	☐ SBA	☐ Mod Ind	☐ Ind

Gait/distance

Clinical information/basics

Vital signs: T _____ P _____
R _____ BP _____

Bowel: ☐ Continent ☐ Incontinent
Bladder: ☐ Continent ☐ Incontinent
Cath/Type: _____

Diet: ☐ NPO or ☐ Type: _____
Tube feeding: ☐ Yes ☐ No

IV/PICC line: ☐ Yes ☐ No

O2 delivery: ☐ None or ☐ Type: _____
Vent: ☐ Yes ☐ No Sat: _____
Vent Settings: _____

Suction frequency/24H: ☐ None or ☐ Freq: _____

Respiratory tx: ☐ Yes ☐ No ☐ Freq: _____

Trach: ☐ None or ☐ Type: _____

Pain location: _____

Pain medication: _____

Route	**Dose**	**Frequency**

Pain scale: _____ **Before management** _____ **After management**

Clinical information/cognition

Alert and oriented X _____ Other: _____

Mobility current functioning (continued)

Gait/assist needed: ☐ Total assist ☐ Max assist ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Mod Ind ☐ Ind

Gait/assistive device: ☐ None or ☐ Type: _____

Stairs:
1.) Current number of stairs can climb: _____
2.) Number of stairs in home: _____

Stairs/assist needed: ☐ Total assist ☐ Max assist ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Mod Ind ☐ Ind

Comments:

Clinical information/medications

List significant medication changes at reassessment that affect functioning:

List IV medications (medication name, dose, frequency, start date, end date):

Medication name

Dose | **Frequency**

Start date | **End date** | **Ending date**

Self-care current functioning

Focus occupational therapy goals:

Bathing/UE: ☐ Total assist ☐ Max assist ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Mod Ind ☐ Ind

Bathing/LE: ☐ Total assist ☐ Max assist ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Mod Ind ☐ Ind

Dressing/UE: ☐ Total assist ☐ Max assist ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Mod Ind ☐ Ind

Dressing/LE: ☐ Total assist ☐ Max assist ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Mod Ind ☐ Ind

Toileting/ Hygiene mgt: ☐ Total assist ☐ Max assist ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Mod Ind ☐ Ind

ADL transfers: ☐ Total assist ☐ Max assist ☐ Mod ☐ Min ☐ CGA ☐ SBA ☐ Mod Ind ☐ Ind

Clinical information/skin status

Skin status: ☐ Intact

If not intact, complete fields below and add pages as needed.

Wound or incision/Location and stage:

Size L x W x D (CM):

Treatment

Wound or incision/Location and stage:

Size L x W x D (CM):

Treatment type and frequency

Speech therapy current status

☐ **None** ☐ **Dysphagia evaluation/Modified barium swallow**

Result/Aspiration risk/Recommendations:

Comment:

Discharge plans (must be initiated upon admission)

Discharge date (tentative)

Home evaluation date

Home/number of levels: ☐ 1 ☐ 2 ☐ 3 ☐ Other: _____

Discharge location ☐ Home alone ☐ HHC/company ☐ Family/support ☐ Other ☐ Assisted living ☐ Long-term care ☐ Adult foster care

Home/number of steps at: ☐ Entry: _____ ☐ Bed/bath: _____

Equipment:

Supervision needs:

Discharge barriers: