Blue Cross Blue Shield of Michigan

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Continuum of Care℠ Skilled Nursing Facility, Acute Rehabilitation Facility Fax Assessment Form Commercial Contracts Only

☐ InterQual® criteria MET ☐ InterQual® criteria Not MET ☐ **RE-SENDING FAX**

☐ **PRECERTIFICATION** ☐ **RECERTIFICATION**

Complete this form and fax it to:
1-866-411-2573
Or E-FAX/E-Mail to continuumofcaresnf@bcbsm.com
Include hospital admission H&P and PM&R consultation notes (as applicable)

Facility and provider must participate with local BCBS plan or member may incur sanctions. If the facility or provider is not participating with the local plan, claims may not pay. Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable.

INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.

CONTINUUM OF CARE DISCLAIMER STATEMENTS AND ATTESTATION

- SNF/REHAB BENEFITS VERIFIED ☐ Yes ☐ No
- ALL THERAPY NOTES ARE WITHIN 24-48 HOURS OF FAX REQUEST ☐ Yes ☐ No
- SNF MEMBER IS RECEIVING AT LEAST 1 HOUR OF THERAPY 5 DAYS A WEEK ☐ Yes ☐ No
- ACUTE REHAB MEMBER IS RECEIVING PT/OT AT LEAST 3 HOURS PER DAY, 5 DAYS PER WEEK AND ABLE TO SIT FOR 1 HOUR A DAY ☐ Yes ☐ No
- THE PRECERTIFICATION AND RECERTIFICATION PROCESS IS NOT A GUARANTEE OF PAYMENT
- MEDICARE EXHAUST: A COPY OF MEDICARE COMMON WORKING FILE (HIQACRO SCREEN) MUST BE FAXED TO 866-589-6426. YOU MUST EXPLAIN HOW ANY REMAINING CWF "CO-SNF DAYS" HAVE BEEN USED. ALLOW 24 HOURS FOR PROCESSING PRIOR TO SENDING FAX REQUEST.
- THIS FAX FORM IS COMPLETED BY LICENSED CLINICAL PERSONNEL

SIGN AND DATE HERE _____

ASSESSMENT TYPE/COVERAGE

Facility type: ☐ SNF ☐ Acute rehabilitation	Number of days requested:

MEMBER/FACILITY/PROVIDER INFORMATION

Member name	Facility NPI#	Facility name
Member BCBSM policy number	BCBSM facility code (MI only)	Facility Address
Member address	Facility reviewer name	Facility main phone number
Member phone number	Reviewer phone/ext	Fax
Hospital date of admission	Facility date of admission/Date BCBSM primary	
Hospital name	Admitting physician	
Attending physician/phone number	BCBSM provider code (MI only)	
DX/Reason for hospital admit (See page 2 for diagnosis specific questions)	Physician address/phone number	
Complications	Alternate contact (PA/NP)	Phone number
Surgical procedure		
Medical history		
Additional Information		

Height	Weight	Prior level of function (home)	ELOS (# of days)

CLINICAL INFORMATION/BASICS

Cognition / A & O: ☐ x1 ☐ x2 ☐ x3
Follows commands _____
Other _____

Vital signs: **T** _____ **P** _____ **R** _____ **BP** _____

Bowel: ☐ Continent ☐ Incontinent
Bladder: ☐ Continent ☐ Incontinent ☐ Cath.

CLINICAL INFORMATION/BASICS – CONTINUED

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

IV/PICC line: ☐ Yes ☐ No
Dosage/Stop date: _____

O2 ☐ Yes ☐ No Liters _____ O2 Sat: _____
Vent: ☐ Yes ☐ No Trach: ☐ Yes ☐ No
Respiratory Tx: ☐ Yes ☐ No
Dosage/Frequency: _____

Pain site: _____
Scale and Mgt: _____

Skin: ☐ Intact ☐ Wound/surgical incision ☐ Pressure Ulcer
Site: _____
Measurement: _____
Tx: _____
(If there are multiple wounds – attach another page or document on page 3)

CONDITION-SPECIFIC PRECERTIFICATION INFORMATION

If the member is being admitted for any diagnosis listed below check applicable diagnosis and complete information for precert and recert.

☐ NEUROLOGICAL DIAGNOSIS (i.e., CVA, SCI, TBI, etc)

Type of Injury _____ Date of onset _____ TPA given ☐ YES ☐ NO

CT/MRI results _____

Associated Symptoms _____

Initial treatment _____

Detailed muscle group strengths _____

_____

Residual from previous CVA ☐ YES ☐ NO Trunk control _____

ASIA score _____ Level of injury _____

Associated injuries _____

Quadriplegia/Paraparesis. Initial Glasgow coma scale _____ Rancho _____

Previous Level of Function: _____ w/c mobility _____ Transfers _____ Assistive device _____

Type of catheter _____ Bowel/Bladder program _____

Coordination _____ Ambulation _____

Speech/swallow deficits _____

Additional Information

☐ ORTHOPEDIC/AMPUTATION/ONCOLOGY

Type of Injury _____

Onset date _____ Surgeries _____

Comorbidities/History of neuropathy _____

Previous Level of Function _____ Weight bearing status _____ ROM (affected limb) _____

Casts/immobilizer ☐ YES ☐ NO Type _____

Amputee: Stump shrinker ☐ YES ☐ NO

Stump description _____

Prosthesis status _____

Chemotherapy: ☐ YES ☐ NO Number received _____

Radiation: ☐ YES ☐ NO Number received _____

Number planned _____ How often _____ Date of last TX _____

Date of next oncology visit _____

Additional Information

☐ RESPIRATORY / DEBILITY

☐ COPD ☐ Asthma ☐ Home 02

Pulse ox _____ On room air _____ On O2/liters _____ Endurance _____

Respiratory failure Vent ☐ YES ☐ NO

Vent settings _____

Weaning status _____

Trach ☐ YES ☐ NO Decannulation Date _____

Lung sounds _____

Suctioning ☐ YES ☐ NO How often _____

Previous Level of Function with date _____

Additional Information

☐ BURNS/SKIN

Affected areas _____

Skin conditions _____

New functional impairments _____

Cognition status _____

PROVIDE FUNCTIONAL LEVEL * ACCORDING TO FIM SCORES *Submit entire form with current clinical for Recerts					
Provide only one level for each function *Key for mobility and self-care functioning: I=independent / Mod I = modified independent / Sup = supervision / SBA = standby assist CGA = contact guard assist Min = minimal / Mod = moderate / Max = maximum / Total = total assist / NT = Not Tested / NA = Not Applicable					
MOBILITY CURRENT FUNCTIONING (Use key above*)					
	PRECERT	RECERT #1	RECERT #2	RECERT #3	RECERT #4
Date of PT/OT notes:					
Bed mobility					
Transfers					
Ambulation/Distance Assist Level Assistive device					
Wheelchair Propulsion/ Distance Assist Level					
Number of stairs N/T or N/A Handrails / Assist level					
Strength (If applicable)					
Balance: BERG (if applicable) Standing static /dynamic Sitting static / dynamic					
OCCUPATIONAL THERAPY / SELF-CARE CURRENT FUNCTIONING (Use key above*)					
Feeding:					
Grooming:					
Bathing / UE:					
LE:					
Dressing / UE:					
LE:					
Toileting:					
ADL transfers:					
Strength / UE:					
LE:					
Long term focus goals:					
Additional Information					
SPEECH THERAPY CURRENT STATUS					
☐ None ☐ Dysphagia/Dysphasia					
Aspiration risk:					
Recommendations:					
Swallow:					
DISCHARGE PLAN					
Tentative date of discharge					
Discharge to (location, Home, LTC, SNF, ALF etc.)					
Support system (availability)					
Home style (ranch, 2 story, apt)					
Number of steps to enter					
Steps to bedroom					
Steps to bathroom					
½ bath main floor (yes/no)					
Can patient stay on main floor					
Discharge needs: DME/other HHC					
Home eval completed? ☐ Yes ☐ No If yes Date/Results					
If ramp needed – What is status?					
Additional Information					