Blue Cross Blue Shield of Michigan

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Medicare Plus Blue PPO℠ Skilled Nursing Facility, Acute Rehabilitation Facility Fax Assessment Form

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

☐ PRECERTIFICATION ☐ RECERTIFICATION

Complete this form and fax it to:
1-866-464-8223
Or E-FAX/E-Mail to MedicarePlusBlueFacilityFax@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. Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable.

INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.

MA PPO DISCLAIMER STATEMENTS AND ATTESTATION

- Number of Medicare Plus Blue SNF days available _____
- All therapy notes are within 24-48 hours of fax request
- SNF member is receiving at least 1 hour of therapy 5 days a week
- Acute rehab member is receiving OT/PT at least 3 hours per day, 5 days per week and able to sit for 1 hour a day
- The precertification and recertification process is not a guarantee of payment
- This fax form is completed by licensed clinical personnel
- Facility and provider must participate with local BCBSM plan or member may incur sanctions
- Please verify eligility and benefits prior request

Sign and date here: _____

ASSESSMENT TYPE/COVERAGE

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

MEMBER/FACILITY INFORMATION

Member name	Age	Address	
Policy number	Member phone number	Hospital	Admission date
Admitting facility and NPI 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	
DX/Reason for hospital admit	
Complications	
Surgical procedure	Date
Medical history	

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

MOBILITY CURRENT FUNCTIONING

Date of PT/OT notes

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: _____

Sat: _____

Vent: ☐ Yes ☐ Settings: _____

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

Respiratory tx: ☐ Yes ☐ No ☐ Freq: _____

Trach: ☐ None or ☐ Type: _____

Pain site: ☐ None ☐ Scale & mgt: _____

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: ☐ Yes ☐ No Number of stairs: _____

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, with ending dates:

SELF-CARE CURRENT FUNCTIONING

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

Focus therapy goal:

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

SPEECH THERAPY CURRENT STATUS

☐ **None** ☐ **Dysphagia eval./Modified barium swallow**

Result/Aspiration risk/Recommendations:

Comment:

DISCHARGE (DC) PLANS (must be initiated upon admission)

Discharge date (tentative)

Home eval/Date

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

Discharge ☐ Home alone ☐ HHC/Company ☐ Family/Support ☐ ALF ☐ LTC ☐ Other

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

Equipment:

DC barriers:

Supervision needs: