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UAW Retiree Medical Benefits Trust
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)

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

SIGN AND DATE HERE ____

ASSESSMENT TYPE/COVERAGE

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

MEMBER/FACILITY INFORMATION

Member name	Age	Address	
Contract number	Member phone number	Hospital	Admission date
Admitting facility (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 ☐ CGA	☐ Max assist ☐ SBA	☐ Mod ☐ Mod Ind	☐ Min ☐ Ind
Transfers:	☐ Total assist ☐ CGA	☐ Max assist ☐ SBA	☐ Mod ☐ Mod Ind	☐ Min ☐ 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:

Supervision needs:

DC barriers: