MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Clinical Review Form - Telephonic Clinical Review

For Medicare Advantage & Federal Employee Program (FEP) members: 1-866-577-9682

For Employees of BCBSMA: 1-617-246-4299

For all other members: 1-888-282-1321

Date of Review: _____

Member Information

Member name: _____

Date of Birth (mm/dd/yyyy): _____

BCBSMA member ID*(include alpha prefix)*: _____

Hospital Information

Hospital Name: _____

Hospital NPI: _____

Contact Person: _____

Contact's Phone: _____

Contact's Fax: _____

Admitting MD Name: _____

Admitting MD Phone: _____

❑ Elective
❑ Emergent
❑ Observation
❑ SDC changed to inpatient
❑ Transfer from another hospital

Admit Date: _____

Discharge Date: _____

❑ Initial Review
❑ Continued Stay Review

Clinical Information

Primary diagnosis: _____

Secondary diagnosis: _____

Procedure(s): _____

Date of procedure: _____

Previous medical history: _____

Failed outpatient treatment *(describe below)*: ❑ Yes ❑ No

Severity of Illness (SI)

Emergency Room treatment: _____

Initial Vital Signs: _____ O2 sat (RA) _____ Peak Flow _____

Clinical Presentation on Admission: *(include all pertinent clinical information)* _____

Lab & Diagnostic information: *(fill out all that apply)*

WBC:		ABGs:		Glucose:	
Neutrophils/ANC:		BUN/Creat:		BNP:	
RBCs:		Na:		Albumin:	
Platelets:		K:		PT/INR:	
Hgb/Hct:		Ca:		PTT:	
Cultures:		Mg:		Other:	

Imaging Results: _____

ECG Findings: _____

Clinical Review Form – Telephonic Clinical Review (continued)

Member name: _____ Member Date of Birth: _____

BCBSMA member ID: _____

Intensity of Illness (IS)

	Medication Name:	Frequency*:	Start Date:	End Date:
IVF/Blood Products:				
IV Meds/TPN:				
IV Meds/TPN:				
NGT/Gtube feeds:				
IM/ SC Meds:				
IM/ SC Meds:				
PO Meds:				
PO Medication Adjustments:				

**For medications given PRN, please note the number of times given within a 24-hour period.*

Additional Treatment

Neuro assessment & frequency: _____

Vital signs/ Orthostatic B/P frequency: _____

Monitoring/Type *(provide changes to treatment due to monitoring)*: _____

Neuro impairment: _____

Respiratory care: _____

Isolation/type: _____

O2/O2 Sats: _____

Wound care/location: _____

Lung sounds chest P.T.: _____

Wound care type/frequency: _____

Nebs/Updrafts/ bronchodilators with frequency: _____

Tubes/drains: _____

Location: _____

Type output: _____

Nutrition:

NPO: ❑ Yes ❑ No

Current Diet: _____

Discharge Planning

Member will be discharged to:

❑ Home with no services ❑ Home with services (e.g., VNA) ❑ Skilled Nursing Facility ❑ Rehab

❑ LTAC (Chronic) ❑ Hospice (home/inpatient) ❑ Anticipate complicated discharge plan

Assessment: _____

Clinical Stability: _____

Skilled Treatment: _____

Functional Status: _____

Barriers: _____