Blue Cross Blue Shield Blue Care Network of Michigan

Medicare Advantage inpatient assessment form

For Medicare Plus Blue[SM] and BCN Advantage[SM]

For Michigan and non-Michigan inpatient facilities

Instructions

For acute inpatient admissions. Submit this completed form and the supporting clinical documentation together to ensure that the request can be processed appropriately and efficiently. Incomplete submissions may result in a delay or a denial.

Attach the following documents:

- Hospital admission H&P, progress notes, consultations, labs, imaging studies and procedures (as applicable).
- Any additional supporting clinical documentation. Include only information that supports Change Healthcare's InterQual® criteria.

How to submit the request:

- **For Michigan facilities:** Submit all requests through the e-referral system. When you're unable to submit a request through the e-referral system, complete this form and fax it together with the required clinical documentation to the appropriate fax number (listed below).
- **For non-Michigan facilities:** Fax the completed form together with the required clinical documentation to the appropriate fax number (listed below).

Fax numbers:

- Medicare Plus Blue: Fax to 1-866-464-8223 or send an e-fax or email to **MedicarePlusBlueFacilityFax@bcbsm.com**.
- BCN Advantage: Fax to 1-866-526-1326.

NOTE: This request is for an acute hospital stay only. In addition:

- Don't use this form for post-acute care requests. For information on post-acute care requests, refer to the document **Post-acute care services: Frequently asked questions for providers**.
- For human organ transplant procedures, use this form only for the inpatient stay request. For the transplant itself:
  - For Medicare Plus Blue members, contact Medicare Advantage Provider Inquiry at 1-866-309-1719.
  - For BCN Advantage members, call 1-800-242-3504 or fax to 1-866-752-5769.
  - Transplant procedures must be performed in facilities approved by Medicare for the procedure that will be performed.
  - If additional assistance is needed for a member, contact our Care Management department at 1-800-845-5982.

ATTESTATION

By submitting this form, you are attesting to the following:

- You've verified the member's eligibility and benefits for inpatient services and you understand that authorization is not a guarantee of payment.
- You understand that facility and professional providers must participate with their local Blue plan or the member may incur higher costs.
- All information is from the day of the inpatient admission. Also include any pertinent information from 24 to 48 hours before the admission.

Type data into every field unless otherwise noted. Enter N/A if not applicable.

Type of request: ☐ Initial authorization

Is this a request that you've sent once and that you're re-sending? ☐ Yes ☐ No

Note: Expedited preservice requests are not accepted for members already receiving treatment. Expedited preservice requests must include a physician's attestation that the services are necessary due to a condition that is jeopardizing the member's life or health.

Is this an expedited preservice request? ☐ No ☐ Yes: For expedited preservice requests, include the name of the physician attesting to the need for an expedited preservice request:

____

PATIENT INFORMATION				
Name	Date of birth	Policy number	Phone number	
Address	City		State	ZIP code

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ADMISSION INFORMATION

☐ Direct admission ☐ ER admission ☐ Elective admission	Inpatient order date	Discharge date (if known)	
Facility name	Facility NPI number	Facility phone number	
Address	City	State	ZIP code
Admitting physician	Physician NPI number	Physician phone number	
Address	City	State	ZIP code

FACILITY CONTACT INFORMATION

Contact name	Title	Contact email	
Date	Contact phone number	Contact fax number	Is clinical information attached as required? ☐ Yes ☐ No

TYPE OF ADMISSION

Select one:

☐ Medical admission. Indicate admitting diagnosis (include ICD-10 code): ______________________

☐ Surgical admission. Indicate:

Diagnosis (include ICD-10 code): ______________________

Surgical procedure *CPT codes: ______________________

Height	Weight	BP	HR	Resp rate	Temp	Pulse Ox

ER treatment

Medical history/Co-morbidities/Family history:

Pertinent lab/Imaging/Other test results:

Admission orders:

Current medications/frequency:

INFORMATION ABOUT INTERQUAL® CRITERIA / LOCAL RULES (as applicable)

Are the InterQual criteria met?
☐ Met ☐ Not met

Which InterQual criteria are being used for the request?

Is there additional clinical documentation that will be submitted to support the determination for the inpatient stay?
☐ Yes ☐ No

If InterQual criteria or Local Rules are not met, select one of the following to continue the inpatient stay determination process:

☐ Send to medical director or secondary review (No other clinical documentation is available now.)

☐ Additional clinical documentation will be submitted that supports InterQual criteria or Local Rules

SKIN STATUS

☐ Intact	**Wound/Incision location**	Stage: ☐ I ☐ II ☐ III ☐ IV ☐ Unstageable	Size: L x W x D (cm)

Description	
Treatment	Frequency

PAIN STATUS

Pain: ☐ Yes ☐ No	Location		Rating (out of 10)	Treatment effective ☐ Yes ☐ No
Pain medications		Dose	Frequency	Route

CARE MANAGEMENT

Blue Cross offers care management assistance for discharge planning.
Would you like a referral made to our Care Management department? ☐ Yes ☐ No

DISCHARGE PLANS (need to be initiated upon admission)

Discharge date (tentative/actual)	Assistive devices
Resides: ☐ Alone ☐ With spouse ☐ With other	Support (check all that apply): ☐ Spouse ☐ Children ☐ Family/friend ☐ HHC ☐ Other
Discharge to home: ☐ Yes ☐ No	Alternative level of care: ☐ Rehabilitation ☐ Adult foster home ☐ Assisted living ☐ Skilled nursing facility ☐ Long-term center ☐ Other: ______________