Blue Cross Blue Shield Blue Care Network of Michigan

Acute inpatient hospital assessment form

For Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠

For Michigan and non-Michigan inpatient facilities

Check one (required): ☐ Blue Cross commercial ☐ BCN commercial ☐ Medicare Plus Blue ☐ BCN Advantage

Important! Before completing this form, verify that the member's Blue Cross Blue Shield of Michigan or Blue Care Network benefits are active and that the proposed services and the desired number of inpatient days are available based on the level of care.

Instructions

How to submit

IMPORTANT: Facilities with access to Availity Essentials™ should submit requests through the e-referral system. If the e-referral system is unavailable or if you don't have access to Availity Essentials, fax this form along with the supporting clinical documentation to:

- Blue Cross commercial requests, including UAW Retiree Medical Benefits Trust (URMBT) non-Medicare —
  - Michigan providers: 1-800-482-1713
  - Non-Michigan providers: 1-866-411-2585
- BCN commercial requests: 1-866-313-8433
- Medicare Plus Blue requests: 1-866-464-8223 or send an e-fax or email to **MedicarePlusBlueFacilityFax@bcbsm.com**
- BCN Advantage requests 1-866-526-1326

Non-Michigan facilities with access to Availity can reach the e-referral system as follows:

1. Log in to Availity.
2. Enter the member's contract number from their ID card. Be sure to include the alpha prefix. Availity will determine the member's plan and take you to the Pre-Service Review for Out-of-Area and Local Members screen.
3. Click *e-referral*, under the Authorization Vendors heading.

What to submit

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.

IMPORTANT:

Attach the following documents:

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

Additional information

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 requirements: Information for providers**.
- **For human organ transplant procedures,** use this form only for the inpatient stay request. For the transplant itself:
  - For Blue Cross commercial and BCN commercial members, call 1-800-242-3504 or fax to 1-866-752-5769.
  - For Medicare Plus Blue members, contact Provider Inquiry at 1-866-309-1719.
  - For BCN Advantage members, contact Provider Inquiry at 1-800-344-8525.
  - Transplant procedures must be performed in facilities approved by Medicare for the procedure that will be performed.
  - If coordination of care assistance is needed for a member, contact our Care Management department at 1-800-845-5982.
  - For more information, see the document titled **Transplants for prior authorization determinations**.
- For Blue Cross commercial and BCN commercial members: If non-emergency air ambulance transport is needed, prior authorization is required. To request prior authorization, follow the instructions on the document titled **Non-emergency air ambulance prior authorization program: Overview for Michigan and non-Michigan providers**. Do this prior to the flight.

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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.

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

Type of request: ☐ Initial authorization ☐ Continued stay / extension of stay

Expedited requests for Blue Cross commercial and BCN commercial members. Expedited preservice requests are not accepted for members already receiving treatment. Expedited preservice requests require **(a)** a provider's attestation that the services are necessary due to a condition that is jeopardizing the member's life or health, and **(b)** that we call the facility; please provide a contact name and phone number that we can reach during business hours.

Expedited requests for Medicare Plus Blue and BCN Advantage members. Providers may submit expedited requests preservice or while a member is already receiving treatment. These requests require (a) a provider's attestation that the provider has determined that this member's life is in jeopardy, or this service is necessary to prevent jeopardizing this member's life, or the provider determined that this service is necessary to alleviate severe pain that cannot adequately be managed without this service, and (b) that we call the facility; please provide a contact name and phone number that we can reach during business hours.

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

PATIENT INFORMATION			
Name	Date of birth (mm/dd/yyyy)	Policy number	Phone number

ADMISSION INFORMATION			
☐ Direct admission ☐ ER admission ☐ Elective admission	Inpatient order date/Admission date (mm/dd/yyyy)	Discharge date, if known (mm/dd/yyyy)	
Facility name	Facility NPI number	Facility phone number	
Address	City	State	ZIP code
Admitting physician	Physician NPI number	Physician phone number	

FACILITY CONTACT INFORMATION			
Contact name			
Date (mm/dd/yyyy)	Contact phone number	Contact fax number	Is clinical information attached as required? ☐ Yes ☐ No

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TYPE OF ADMISSION

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

☐ Surgical admission. Indicate diagnosis (include ICD code):

Surgical procedure CPT codes:

CARE MANAGEMENT

Blue Cross offers care management assistance for discharge planning.

Would you like a referral made to our Care Management department? ☐ Yes ☐ No

For URMBT requests only: Discharge plans (need to be initiated upon admission)

Discharge date – tentative / actual (mm/dd/yyyy)	Resides: ☐ Alone ☐ With spouse ☐ With other	Support (check all that apply): ☐ Spouse ☐ Children ☐ Family/Friend ☐ HHC ☐ Other

Discharge to home: ☐ Yes ☐ No

If no, indicate alternative level of care:

☐ Rehabilitation ☐ Adult foster home ☐ Assisted living ☐ Skilled nursing facility ☐ Long-term center

☐ Other: _____

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.