Blue Cross Blue Shield of Michigan

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Commercial PPO LTAC/SNF Enhancement Form

☐ **Initial Request** ☐ **Extension**
Complete this form and fax it to
1-866-411-2573

☐ **LTAC** ☐ **SNF Enhancement (Michigan Facilities Only)**

Disclaimer Statements and Attestation:

- Please allow 24-72 hours for processing precertification and recertification requests.
- Precertification is not a guarantee of payment.
- Facility and provider must participate with local Blue Cross plan or member may incur higher costs.
- Please verify eligibility and benefits prior to request.
- All therapy notes must be within 24 to 48 hours of admission or last covered day.
- Is this a Medicare exhaust request: ☐ **Yes** ☐ **No**
- Medicare Exhausts: A copy of the Medicare Common Working File (HIQACRO) screen must be included with the request
- Transfers/approvals may be delayed due to a lack of information provided

Complete every field unless otherwise noted. Enter N/A if not applicable.
Incomplete or illegible submissions will be returned unprocessed.

Contact information

Contact name		Title & Facility	
Date	Contact phone number	Fax number	E-mail

Patient information

Name		Date of birth	Policy number		
Address		City	Telephone	State	ZIP code
Advance directives ☐ Yes ☐ No If yes, please attach copy					

Admission demographics

Admission date	Facility name	NPI number	Estimated length of stay (# of days)	
Facility address		City	State	Zip
Participates with local PPO: ☐ Yes ☐ No		Facility phone number	Facility fax number	
Transfer from (facility name)		Other:	Acute hospital admission date	
Current treating physician		Current treating physician phone ( )		
Admitting diagnosis with ICD 10 Code				

Request Information

Number of days requested ☐ 7 days ☐ 14 days ☐ 21 days ☐ LTAC Level (MI Only) _____	Extension request	Last covered day	Total number of days previously approved

Current clinical information

Height	Weight	Blood pressure	Heart rate	Respiratory rate	Temperature	Alert and oriented
Acute diagnosis			Co-morbidities 1) 2)			
Treatments:					Medical condition stabilized ☐ Yes ☐ No	
Pertinent medical history:						
Surgeries/procedures 1)					Date	
2)					Date	
Dialysis: ☐ Yes ☐ No Type: _____ Frequency: _____						

Physical therapy

Prior level of function (include self-care)

Rehabilitation therapy: ☐ Yes ☐ No | Modality: ☐ PT ☐ OT ☐ SLP | Therapy tolerance: ☐ 1-3 hrs/day x 5 days/week

Bed mobility: ☐ Total assist ☐ Max ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind
Transfers: ☐ Total assist ☐ Max ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind

Ambulation distance | Ambulation device(s)

Ambulation assistance: ☐ Total assist ☐ Max ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind

Stairs: ☐ N/A #Stairs: _____ ☐ Total Assist ☐ Max ☐ Min ☐ CGA ☐ SBA ☐ SUPV ☐ Ind Device: _____

Occupational therapy

Bathing (upper body):	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Bathing (lower body):	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Dressing (upper body):	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Dressing (lower body):	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
Toileting/Hygiene:	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind
ADL/Toileting transfers:	☐ Total assist	☐ Max	☐ Min	☐ CGA	☐ SBA	☐ SUPV	☐ Ind

Speech therapy

☐ None ☐ Dysphagia evaluation | Modified barium swallow result

Risk/recommendations

***Overall focus – goal of therapy**

Skin status

☐ Intact | **Wound/incision location #1** | Stage: ☐ I ☐ II ☐ III ☐ IV ☐ Unstageable | Size: L x W x D (cm)

Description

Treatment | Frequency

☐ Intact | **Wound/incision location #2** | Stage: ☐ I ☐ II ☐ III ☐ IV ☐ Unstageable | Size: L x W x D (cm)

Description

Treatment | Frequency

SNF Enhancement Request

Medication/Infusion ☐ Drug Name Dose/Frequency Other Information:

DME ☐ Type of Equipment Approximate Length of Time Other Information:

Other Information:

Pain status

Pain: ☐ Yes ☐ No | Location | Rating before medication (out of 10) _____

Pain medication name

Dose | Frequency | Route | Effective: ☐ Yes ☐ No | Rating after medication (out of 10) _____

LTAC Vent Weaning

Oximetry	Vent: ☐ Yes ☐ No	Venti mask/liters	NC/liters
Vent rate	Setting	PEEP	FiO2

Tracheostomy: ☐ Yes ☐ No	Date inserted	Decannulation trial
		Duration of spontaneous breathing trail (include device used, e.g. T-Bar, Oxygen)

Clinical status	**If no, provide reason:**		
CXR Stable/Improving	☐ Yes	☐ No	
Telemetry/cardiac rhythm	☐ Yes	☐ No	
Neurologically stable past 24 hours	☐ Yes	☐ No	
Continuous sedation or paralytic agent infusions	☐ Yes	☐ No	☐ N/A
NYHA Class < IV (include ejection fraction)	☐ Yes	☐ No	☐ N/A
Spontaneous breathing trail	☐ Yes	☐ No	☐ N/A

Respiratory therapies

Chest physiotherapy	Frequency:	Nebulizer treatments	Frequency:
Oxygen adjustments (based on oximetry)	Frequency:	Suctioning	Frequency:

Most current:	Hct	Hgb	Date	Stable: ☐ Yes ☐ No	Blood products: ☐ Yes ☐ No

Other pertinent lab results

Invasive lines

IV medication name (1)	Dose	Frequency	Ending date
IV medication name (2)	Dose	Frequency	Ending date

Feeding tube: ☐ Yes ☐ No New to patient: ☐ Yes ☐ No Type:	Amount of feeding	Duration

Discharge plans (Must be filled out on initial request)

Discharge date (tentative/actual)	**Assistive devices**	**Resides:** ☐ Alone ☐ w/Spouse ☐ w/Other

Name of Support and Phone Number

	Name	Phone Number		Name	Phone Number
☐ Spouse:			☐ Family/friend:		
☐ Children:			☐ Home health care:		
☐ Children:			☐ Other:		

Home description (levels, bed/bath location, steps to enter, etc.)

Discharge to home: ☐ Yes ☐ No	**Alternative level of care:**	☐ Rehab	☐ Assisted living	☐ Skilled nursing facility
		☐ Adult foster home	☐ Long term center	☐ Other:

Additional Pertinent Information