Blue Cross Blue Shield of Michigan

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Medicare Plus Blue SM PPO non-Michigan LTACH Fax Assessment Form

Resending fax **Precertification** **Recertification**

Urgent reason: ____________________

Complete this form and fax it to: 1-866-464-8223
Or e-fax/email to MedicarePlusBlueFacilityFax@bcbsm.com
ATTN Michigan providers: for admission authorization of Medicare Plus Blue PPO members who reside in Michigan, please contact eviCore Healthcare at 1-877-917-BLUE or or fax this form to eviCore at 844-407-5293.

LTAC weaning program **LTAC medical**

Please allow 24 hours for processing precertification and recertification requests.

- The precertification and recertification process isn't a guarantee of payment
- This fax form is completed by licensed clinical personnel.
- Facility and provider must participate with local Blue Cross plan or member may incur higher costs.
- Please verify eligility and benefits prior to request.
- All therapy notes must be within 24 to 48 hours of admission or last covered day.

Complete every field unless otherwise noted. Information must be legible. Enter N/A if not applicable.

Incomplete submissions will be returned unprocessed.

Contact information

Contact name	Title	Signature	
Date	Contact phone number	Fax number	E-mail

Patient information

Name	Date of birth	Policy number	
Address	City	State	ZIP code

Admission demographics

Precertification

Admission date (LTACH)	Number of days requested	Facility name (LTACH)	Estimated length of stay (# of days)
Participates with local MA PPO: Yes No		Facility NPI number	Facility phone number

Facility address	City	State	ZIP code
Admitting physician (LTACH) name/address	City	State	ZIP code

Physician provider identification #	Physician phone number	Transfer from (facility name)	Other: Home Dr's office
Acute hospital admission date	Admitting diagnosis with synopsis of acute hospital admission (include pertinent radiology results)		

Recertification

Number of days requested 7 days 14 days 21 days	Current estimated length of stay	Last covered date	Total number of days previously approved

Current clinical information

Height	Weight	Blood pressure	Heart rate	Respiratory rate	Temperature	Alert and oriented

Acute diagnosis (LTACH)

Treatments:	Medical condition stabilized Yes No

Medical history:

Surgeries/procedures 1)	Date
2)	Date

Vent weaning/respiratory complex

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

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

Clinical status				**If no, provide reason:**
CXR Stabie/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	Amount of feeding	Duration

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

Comments (use additional pages if necessary)

Pain status

Pain: Yes No	Location			Rating after medication (out of 10) ___________
Pain medication name				
Dose	Frequency	Route	Effective: Yes No	Rating after medication (out of 10) ___________

Discharge plans (needs to be initiated upon admission)

Discharge date (tentative/actual)	**Assistive devices**
Resides: Alone w/Spouse w/Other	**Support:** Spouse Children Family/friend Home health care 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: ___________

Signature	Title	Date