



A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Acute Inpatient Fax Assessment Form

Precertification Recertification

For Blue Cross commercial members other than UAW Retiree Medical Benefits Trust (URMBT), complete this form and fax it to 1-866-411-2585
For Blue Cross commercial URMBT members, complete this form and fax it to 1-866-915-9811

Precertification isn't a guarantee of payment. Facilities and other health care providers must verify patient eligibility and benefits prior to making precertification requests. If the facility or the provider isn't participating with the local plan, claims may not pay. If the facility or provider isn't participating with a member's contract network, a member may incur higher costs. This approval is based on an acute hospital stay only; this is not an approval for long-term acute care facilities. All Commercial LTAC requests must be submitted on LTAC form.

Incomplete submissions will be returned unprocessed.

REQUEST FOR HUMAN ORGAN TRANSPLANTS						
If this authorization request is for an organ transplant and authorization has not been obtained, call the Human Organ Transplant Program department at 1-800-242-3504 .						
REQUEST FOR AIR AMBULANCE TRANSPORTATION						
If this request is to authorize air ambulance transport or if air ambulance transport may be needed during the admission, call Alacura Medical Transport Management at 1-844-425-2287 . In addition, follow the instructions on the Air Ambulance Flight Information form to submit clinical documentation to Alacura.						
Transferring facility				Admitting facility		
PATIENT INFORMATION						
Name		Date of Birth	Policy number	Phone number		
Address		City	State	ZIP Code		
PRECERTIFICATION						
Direct admit	ER admit	Elective admit	Observation	Admission date	Estimated length of stay	
Facility name			Facility NPI number		Facility phone number	
Address		City	State	ZIP Code		
Admitting physician			Physician provider NPI number		Physician phone number	
Address		City	State	ZIP Code		
RECERTIFICATION						
Number of days requested 3 days 5 days 7 days		Current estimated length of stay			Last covered date	
FACILITY CONTACT INFORMATION						
Contact name			Title	Signature		
Date	Contact phone number		Fax number		Email	
SURGICAL ADMISSIONS						
Surgical procedure and ICD-10 CM PCS codes 1)					Surgery date	
2)						
MEDICAL ADMISSIONS						
Admitting diagnosis and ICD-10 CM codes 1)						
2)						
Height	Weight	BP	HR	Resp rate	Temp	Pulse Ox

ER/Admission assessment and treatment:

Medical history/Co-morbidities/Family history:

Pertinent lab/Imaging/Other test results:

Admission orders/Current treatment plan:

Current medications/frequency:

SKIN STATUS								
Intact	Wound/Incision location #1	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	

CASE MANAGEMENT	
BCBSM offers case management assistance for discharge planning. Would you like a referral made to our case management department?	Yes No

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

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