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Acute Inpatient Fax Assessment Form

Re-sending fax
Precertification
Recertification

Complete this form and fax it to: 1-866-411-2585
For URMBT, fax form to 1-866-915-9811
 Include hospital admission H&P and PM&R consultation notes (as applicable)

Please allow 24-48 hours for processing precertification and recertification requests. 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.

Human organ transplant							
If this admission is for an organ transplant and authorization has not been obtained, please call the Human Organ Transplant Program department at 1-800-242-3504.							
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		E-mail		
Surgical admissions							
Surgical procedure and ICD-10 CM PCS codes						Surgery date	
1)							
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			Home health care		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: _____	