



**Blue Cross
Blue Shield**
of Michigan

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

**Medicare Plus Blue PPOSM
LTACH Fax
Assessment Form**

InterQual[®] criteria MET InterQual[®] criteria Not MET RE-SENDING FAX
 PRECERTIFICATION **RECERTIFICATION**

Complete this form and fax it to:
1-866-464-8223
Or E-FAX/E-Mail to MedicarePlusBlueFacilityFax@bcbsm.com
Include hospital admission H&P and PM&R consultation notes (as applicable)

- Vent Wean Resp Complex
 ID/Wound Med Complex

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	Contract 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 w/local MA PPO: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Home <input type="checkbox"/> Dr's office
Acute hospital admission date	Admitting diagnosis with synopsis of acute hospital admission (include pertinent radiology results)			

RECERTIFICATION

Number of days requested	Current estimated length of stay	Last covered date	Total number of days previously approved
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CURRENT CLINICAL INFORMATION

Height	Weight	BP	HR	Resp Rate	Temp
Acute diagnosis (LTACH)					
Treatments:					Medical condition stabilized <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical history:					
Surgeries/Procedures					Date
1)					Date
2)					

VENT WEANING/RESPIRATORY COMPLEX

Oximetry	Vent: <input type="checkbox"/> Yes <input type="checkbox"/> No	Venti mask/Liters	NC/Liters
Vent rate	Setting	PEEP	FiO2
Tracheostomy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date inserted	Decanulation trial	

Clinical Status				If no, provide reason:			
CXR Stable/Improving				<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	
Telemetry/Cardiac rhythm				<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	
Neurologically stable last 24 hours				<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____	
Continuous sedation/Paralytic agent infusions				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
NYHA Class < IV				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Spontaneous breathing trial				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	_____
Respiratory therapies							
Chest physiotherapy				Frequency: _____		Nebulizer treatments	
Oxygen adjustments (based on oximetry)				Frequency: _____		Suctioning	
Frequency: _____				Frequency: _____		Frequency: _____	
Most current:	Hct	Hgb	Date	Stable: <input type="checkbox"/> Yes <input type="checkbox"/> No		Blood products: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other pertinent lab results							
Invasive lines							
IV medications							Ending date
							Ending date
Feeding tube: <input type="checkbox"/> Yes <input type="checkbox"/> No				New to patient: <input type="checkbox"/> Yes <input type="checkbox"/> No		Amount of feeding	Duration
PHYSICAL THERAPY							
Rehabilitation therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No			Modality: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP			Therapy tolerance: <input type="checkbox"/> 1-3 hrs/day x5 days/week	
Bed mobility:		<input type="checkbox"/> Total assist	<input type="checkbox"/> Max	<input type="checkbox"/> Min	<input type="checkbox"/> CGA	<input type="checkbox"/> SBA	<input type="checkbox"/> SUPV <input type="checkbox"/> Ind
Transfers:		<input type="checkbox"/> Total assist	<input type="checkbox"/> Max	<input type="checkbox"/> Min	<input type="checkbox"/> CGA	<input type="checkbox"/> SBA	<input type="checkbox"/> SUPV <input type="checkbox"/> Ind
Ambulation distance				Ambulation device(s)			
Ambulation assistance: <input type="checkbox"/> Total assist <input type="checkbox"/> Max <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> SUPV <input type="checkbox"/> Ind							
Stairs: <input type="checkbox"/> N/A #Stairs: _____ <input type="checkbox"/> Total Assist <input type="checkbox"/> Max <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> SUPV <input type="checkbox"/> Ind Device: _____							
OCCUPATIONAL THERAPY							
Bathing: Upper body		<input type="checkbox"/> Total assist	<input type="checkbox"/> Max	<input type="checkbox"/> Min	<input type="checkbox"/> CGA	<input type="checkbox"/> SBA	<input type="checkbox"/> SUPV <input type="checkbox"/> Ind
Bathing: Lower body		<input type="checkbox"/> Total assist	<input type="checkbox"/> Max	<input type="checkbox"/> Min	<input type="checkbox"/> CGA	<input type="checkbox"/> SBA	<input type="checkbox"/> SUPV <input type="checkbox"/> Ind
Dressing: Upper body		<input type="checkbox"/> Total assist	<input type="checkbox"/> Max	<input type="checkbox"/> Min	<input type="checkbox"/> CGA	<input type="checkbox"/> SBA	<input type="checkbox"/> SUPV <input type="checkbox"/> Ind
Dressing: Lower body		<input type="checkbox"/> Total assist	<input type="checkbox"/> Max	<input type="checkbox"/> Min	<input type="checkbox"/> CGA	<input type="checkbox"/> SBA	<input type="checkbox"/> SUPV <input type="checkbox"/> Ind
Toileting/Hygiene:		<input type="checkbox"/> Total assist	<input type="checkbox"/> Max	<input type="checkbox"/> Min	<input type="checkbox"/> CGA	<input type="checkbox"/> SBA	<input type="checkbox"/> SUPV <input type="checkbox"/> Ind
ADL/Toileting transfers:		<input type="checkbox"/> Total assist	<input type="checkbox"/> Max	<input type="checkbox"/> Min	<input type="checkbox"/> CGA	<input type="checkbox"/> SBA	<input type="checkbox"/> SUPV <input type="checkbox"/> Ind
SPEECH THERAPY							
<input type="checkbox"/> None <input type="checkbox"/> Dysphagia evaluation			Modified barium swallow results				
Risk/Recommendations							
*Overall focus goal of therapy(s)							
SKIN STATUS							
<input type="checkbox"/> Intact	Wound/Incision location #1			Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unstageable			Size: L x W x D (cm)
Description							
Treatment						Frequency	

