



**Blue Cross  
Blue Shield**  
of Michigan

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

**Medicare Plus Blue PPO<sup>SM</sup>  
Skilled Nursing Facility,  
Acute Rehabilitation Facility  
Fax Assessment Form**

InterQual<sup>®</sup> criteria MET  InterQual<sup>®</sup> 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](mailto:MedicarePlusBlueFacilityFax@bcbsm.com)  
Include hospital admission H&P and PM&R consultation notes (as applicable)

Facility and provider must participate with local BCBS plan or member may incur sanctions. Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable.

**INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.**

<b>MA PPO DISCLAIMER STATEMENTS AND ATTESTATION</b>					
<ul style="list-style-type: none"> <li>NUMBER OF MEDICARE PLUS BLUE SNF DAYS AVAILABLE _____</li> <li>ALL THERAPY NOTES ARE WITHIN 24-48 HOURS OF FAX REQUEST</li> <li>SNF MEMBER IS RECEIVING AT LEAST 1 HOUR OF THERAPY 5 DAYS A WEEK</li> <li>ACUTE REHAB MEMBER IS RECEIVING OT/ PT AT LEAST 3 HOURS PER DAY, 5 DAYS PER WEEK AND ABLE TO SIT FOR 1 HOUR A DAY</li> <li>THE PRECERTIFICATION AND RECERTIFICATION PROCESS IS NOT A GUARANTEE OF PAYMENT</li> <li>THIS FAX FORM IS COMPLETED BY LICENSED CLINICAL PERSONNEL</li> </ul>					
SIGN AND DATE HERE _____					
<b>ASSESSMENT TYPE/COVERAGE</b>					
Facility type: <input type="checkbox"/> SNF <input type="checkbox"/> Acute rehabilitation			Number of days requested:		
<b>MEMBER/FACILITY INFORMATION</b>					
Member name		Age	Address		
Contract number	Member phone number		Hospital	Admission date	
Admitting facility and NPI number			Phone number	Facility reviewer name	
Fax number		Address			
<b>ADMISSION INFORMATION</b>			<b>CLINICAL INFORMATION/BASICS</b>		
Admission date to SNF/IPR		Admitting doctor (first/last name and NPI#)			
Physician address/phone number			<b>Vital signs:</b> T _____ P _____ R _____ BP _____		
DX/Reason for hospital admit			<b>Bowel:</b> <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <b>Bladder:</b> <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent Cath/Type: _____		
			<b>Diet:</b> <input type="checkbox"/> NPO or <input type="checkbox"/> Type: _____ <b>Tube feeding:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
Complications			IV/PICC line: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Surgical procedure		Date			
Medical history			<b>O2 delivery:</b> <input type="checkbox"/> None or <input type="checkbox"/> Type: _____ <b>Sat:</b> _____ <b>Vent:</b> <input type="checkbox"/> Yes Settings: _____		
			<b>Suction frequency/24H:</b> <input type="checkbox"/> None or <input type="checkbox"/> Freq: _____		
Height	Weight	Prior level of function (home)	ELOS (# of days)		
Respiratory tx: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Freq: _____			<b>Trach:</b> <input type="checkbox"/> None or <input type="checkbox"/> Type: _____		
<b>MOBILITY CURRENT FUNCTIONING</b>					
Date of PT/OT notes			Pain site: <input type="checkbox"/> None <input type="checkbox"/> Scale & mgt: _____		
<b>Bed mobility:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind			<b>CLINICAL INFORMATION/COGNITION</b>		
<b>Transfers:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind			Alert and oriented X _____		
Gait/Distance			Other: _____		

MOBILITY CURRENT FUNCTIONING (Continued)		CLINICAL INFORMATION/MEDICATIONS
<b>Gait/Assist needed:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind		<b>List significant medication changes at reassessment that affect functioning:</b>
<b>Gait/Assistive device:</b> <input type="checkbox"/> None or <input type="checkbox"/> Type: _____		
<b>Stairs:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    Number of stairs: _____		
<b>Stairs/Assist needed:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind		<b>List IV medications, with ending dates:</b>
<b>Comments:</b>		
SELF-CARE CURRENT FUNCTIONING		CLINICAL INFORMATION/SKIN STATUS
<b>Bathing/UE:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind		<b>Skin status:</b> <input type="checkbox"/> Intact <b>If not intact, complete fields below and add pages as needed.</b>
<b>Bathing/LE:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind		
<b>Dressing/UE:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind		<b>Wound or incision/Location and stage:</b>
<b>Dressing/LE:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind		
<b>Toileting/ Hygiene mgt:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind		Size L x W x D (CM):
<b>ADL transfers:</b> <input type="checkbox"/> Total assist <input type="checkbox"/> Max assist <input type="checkbox"/> Mod <input type="checkbox"/> Min <input type="checkbox"/> CGA <input type="checkbox"/> SBA <input type="checkbox"/> Mod Ind <input type="checkbox"/> Ind		Treatment
<b>Focus therapy goal:</b>		<b>Wound or incision/Location and stage:</b>
SPEECH THERAPY CURRENT STATUS		Size L x W x D (CM):
<input type="checkbox"/> None <input type="checkbox"/> Dysphagia eval./Modified barium swallow <b>Result/Aspiration risk/Recommendations:</b>		Treatment
<b>Comment:</b>		
DISCHARGE (DC) PLANS (must be initiated upon admission)		
<b>Discharge date (tentative)</b>	<b>Home eval/Date</b>	<b>Home/number of levels:</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other: _____
<b>Discharge</b> <input type="checkbox"/> Home alone <input type="checkbox"/> HHC/Company <input type="checkbox"/> Family/Support <input type="checkbox"/> ALF <input type="checkbox"/> LTC <input type="checkbox"/> Other		<b>Home/number of steps at:</b> <input type="checkbox"/> Entry: _____ <input type="checkbox"/> Bed/bath: _____
<b>Equipment:</b>		<b>DC barriers:</b>
<b>Supervision needs:</b>		