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**UAW Retiree Medical Benefits Trust
Medicare Plus Blue PPOSM
Skilled Nursing Facility,
Acute Rehabilitation Facility
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)

Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable.
INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.

MA PPO DISCLAIMER STATEMENTS AND ATTESTATION

- NUMBER OF MEDICARE PLUS BLUE SNF DAYS AVAILABLE _____
- ALL THERAPY NOTES ARE WITHIN 24-48 HOURS OF FAX REQUEST
- SNF MEMBER IS RECEIVING AT LEAST 1 HOUR OF THERAPY 5 DAYS A WEEK
- 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
- THE PRECERTIFICATION AND RECERTIFICATION PROCESS IS NOT A GUARANTEE OF PAYMENT
- THIS FAX FORM IS COMPLETED BY LICENSED CLINICAL PERSONNEL

SIGN AND DATE HERE _____

ASSESSMENT TYPE/COVERAGE

Facility type: SNF Acute rehabilitation Number of days requested: _____

MEMBER/FACILITY INFORMATION

Member name		Age	Address	
Contract number	Member phone number		Hospital	Admission date
Admitting facility (NPI number)		Phone number	Facility reviewer name	
Fax number	Address			

ADMISSION INFORMATION		CLINICAL INFORMATION/BASICS	
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Admission date to SNF/IPR		Admitting doctor (first/last name and NPI#)		Vital signs: T _____ P _____ R _____ BP _____	
Physician address/phone number				Bowel: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent Bladder: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent Cath/Type: _____	
DX/Reason for hospital admit				Diet: <input type="checkbox"/> NPO or <input type="checkbox"/> Type: _____ Tube feeding: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Complications				IV/PICC line: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Surgical procedure		Date		O2 delivery: <input type="checkbox"/> None or <input type="checkbox"/> Type: _____ Sat: _____ Vent: <input type="checkbox"/> Yes Settings: _____	
Medical history				Suction frequency/24H: <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: _____	

MOBILITY CURRENT FUNCTIONING

Date of PT/OT notes _____

Trach: None or Type: _____

Pain site: None Scale & mgt: _____

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