BlueCross BlueShield of Illinois

SNF, IRF, LTACH PAC Authorization Form

eviCore healthcare innovative solutions

☐ Resending fax
☐ Precertification
☐ Recertification

Expedited reason*_____ (see below)

Complete this form and fax it to **1-855-826-3725**. *Please provide supporting clinical documentation where applicable.* Call **1-855-252-1117** to speak with a representative.

The facility and provider must participate with the local Blue plan or the member may incur higher costs. Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable. Precertifications and recertifications are not a guarantee of payment. Incomplete submissions will be returned unprocessed.

Disclaimer statements and attestation

- Verify eligibility and benefits prior to request. SNF/LTACH or IRF benefits verified ☐ Yes ☐ No
  If "yes", number of days available_____
- Is the admission a result of a motor-vehicle accident or workplace injury? ☐ Yes ☐ No
- All therapy notes are within 24-48 hours of admission date (Initial) or 72 hrs prior to last covered date (Concurrent) ☐ Yes ☐ No
- SNF member is receiving at least one hour of therapy five days a week? ☐ Yes ☐ No
- IRF member is receiving PT or OT at least three hours per day/five days per week and able to sit for one hour per day ☐ Yes ☐ No

Is the 3 day waiver being utilized? ☐ Yes ☐ No Was this an observation stay? ☐ Yes ☐ No

Sign and date here: _____

Documents to attach: History & Physical; Discharge Summary (if available); Clinical Progress Notes (for recertification requests); Medication list; Therapy notes including level of participation (evaluation and last progress notes)

Assessment type/coverage

Facility type: ☐ SNF ☐ IRF ☐ LTACH | **ELOS** (# of days)

Member/facility information

Member name	Date of birth	Address	
Policy number	Member phone number	Hospital	Admission Date
Admitting facility and NPI/PIN number	Phone number	Fax number	
Facility address	Facility reviewer name		

Patient information

Primary Caregiver	Contact number	☐ Child ☐ Spouse ☐ Friend ☐ Self ☐ Paid caregiver

Residence prior to admission to hospital: ☐ Lives alone ☐ Lives with family ☐ Lives with paid caregiver ☐ Homeless ☐ Shelter ☐ Assisted living facility ☐ Long term care/NH

Advance Directive ☐ Yes ☐ No **DNR status** ☐ Yes ☐ No

Admission information

Admission date to SNF/IRF/LTACH

Admitting doctor (first/last name and NPI#)

Physician address/phone number

Hospital admitting diagnosis and ICD10 code

Complications

Surgical procedure | Date

Medical history

Risk factors: ☐ Smoker ☐ Etoh abuse ☐ Dementia ☐ Urinary incontinence ☐ Chronic pain ☐ Recent Amputation ☐ Hx of falls <90 days ☐ Multiple Medications ☐ None

Clinical information

Vital signs: T_____ HR_____ R_____ BP_____
Height_____ Weight_____

Isolation Precautions ☐ Yes ☐ No If "yes" type:_____

Sensory Status: ☐ Alert and oriented x _____
☐ Confused ☐ Deaf ☐ Blind
☐ Ability to speak ☐ Unable to read
☐ Ability to follow simple commands

Primary Language spoken_____

Diet: ☐ NPO ☐ Regular ☐ Soft ☐ Mech soft ☐ Puree ☐ Liquid
Other:_____
Tube feeding: ☐ Yes ☐ No If "yes" type:_____

Respiratory: 02 Sat: _____ ☐ Room Air ☐ On 02
02 delivery: ☐ None Type:_____
Resp tx ☐ Yes ☐ No Freq/Type:_____
Trach: ☐ Yes ☐ No
Vent: ☐ Yes ☐ No
Settings: _____
Suction ☐ Yes ☐ No #/24H:_____
Route: ☐ Nasal ☐ Trach ☐ Oral

Bowel: ☐ Continent ☐ Incontinent
Bladder: ☐ Continent ☐ Incontinent
Cath/type:_____

*The Medicare health plan must expedite the review of determination if the plan finds that applying the standard time for making a determination could seriously jeopardize the enrollee's health, life, or ability to regain maximum function. A decision must be rendered as expeditiously as the enrollee's health condition might require, but no later than 72hrs after receiving the request.

Mobility and functional status

Prior level of functioning (home):
Ambulation: # feet _____ Assist device used: ☐ Yes ☐ No
Ability to perform ADL's: ☐ Dependent ☐ Max Assist ☐ Mod Assist ☐ Min Assist ☐ Independent
Ability to perform IADL's: ☐ Dependent ☐ Max Assist ☐ Mod Assist ☐ Min Assist ☐ Independent

Goal of physical therapy:

Date of PT/OT notes:

BIMS SCORE:
Weight Bearing status:

Current Level of Functioning: ☐ Independent ☐ Mod Assist ☐ Stand By Assist ☐ Contact Guard Assist ☐ Dependent

Bed mobility: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent
Transfers: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent
Toileting Transfers: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Stairs/assist needed ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Gait/distance: _____
Gait assist needed: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent
Gait assist device: ☐ None Type:_____
Needs assist with device: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Dressing/UE: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent
Dressing/LE: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Telephone Use: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Toileting: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Bathing/UE: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent
Bathing/LE: ☐ Dependent ☐ Max assist ☐ Mod assist ☐ Min assist ☐ Independent

Occupational Therapy

Goal of Occupational therapy:

Speech therapy current status

☐ **None** ☐ **Dysphagia evaluation/modified barium swallow**

Result/aspiration risk/recommendations:

Comment:

Discharge plans (must be initiated upon admission)

Discharge date (tentative)

Home evaluation date

Discharge Location ☐ **Home alone** ☐ **HHC/Company** ☐ **Family/Support** ☐ **Other** ☐ **Assisted living** ☐ **Long term care** ☐ **Adult foster care**

Equipment:

Supervision needs:

Clinical information continued

Pain location:_____
Pain Scale: _____ ☐ **Before Medication** ☐ **After Medication**

Pain Medication	Route	Dose	Frequency

Skin status: ☐ Intact
If not intact, complete fields below and attach additional information as necessary.

Wound or Incision/ location and stage:	Size: L x W x D(CM):

Treatment:

Medications

List significant medication changes at reassessment:

IV/PICC line: ☐ **Yes** ☐ **No**

List IV medications (medication name, dose, frequency, start date, end date):

Medication name:

Dose:	Frequency:
Start Date:	**End Date:**

Follow up Specialist Appointment(s)

Ortho appointment date: _____
Outcome of appointment: _____

Wound care specialist appointment date: _____
Outcome/changes to wound care:_____

Other specialist appointment date: _____
Outcome: _____

Home/number of levels: ☐ **1** ☐ **2** ☐ **3**
Other:_____

Home/number of steps at: Entry_____
Bed/Bath:_____

Discharge barriers: