



of Tennessee

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Chattanooga, TN 37402

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BlueAdvantageSM
**Skilled Nursing Facility/
Inpatient Rehabilitation Fax Form**

- Confidential -

Initial Request: _____ **Concurrent Review:** _____

Inpatient Rehabilitation

Skilled Nursing Facility Level I Level II Level III

Member Information

Member Name: _____ Date of Birth: _____

Member Identification Number: _____ Reference Number: _____

Member Current Telephone Number: _____

SNF / Inpatient Rehabilitation Facility Information

Expected Date of Admission to Facility: _____

Facility Name: _____ Contact Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ Tax Identification Number: _____

Facility member is transferring from: _____

Ordering Physician Information

Prescribing Physician's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ Tax Identification Number: _____

Admitting Physician Information

Facility Physician's Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ Tax Identification Number: _____

The above information should be obtained with the on-line authorization process.

Clinical Information

Diagnosis: _____

Height: _____ Weight: _____

Current Lab (e.g., hemoglobin & hematocrit, INR, PTT): _____

Has a Doppler study of the lower extremities been performed? Yes No

If yes, date of the last Doppler study (lower extremities)? _____

Patient Level of Orientation

Rancho Level

Alert and Oriented Willing and Able to Participate Can Follow Commands

Types of Discipline (Therapy): Speech Occupational Physical

Number of Therapy Hours per Day: _____ Number of Modalities per Day: _____

Type of Surgery: _____

Date of Surgery: _____

Pain Control (by discharge): PO IV Please specify:

Comorbidity/Past Medical History: _____

Functional Status Prior to Admission:

Home Environment:

Single or Multi Level: _____ Number of steps to enter home: _____

Number of steps within home: _____ Availability of caregiver: _____

Current Functional Status (DAY PRIOR TO DISCHARGE from Acute Care Facility)						
FIMS Score (1 - 7)	Minimum	Moderate	Maximum	CGA	SBA	Assistive Devices
Eating						
Dressing						
Bathing						
Bed / Mobility						
Supine / Sit						
Sit / Stand						
Transfers						
Ambulation **Distance**						

Wound Care description: (length, width, drainage), treatment, frequency:

Progress toward goals/Changes in Plan of Care:

Caregiver teaching/training:

If Skilled Nursing Facility request, what are other skilled needs? (e.g., IV antibiotics, TPN, oxygen, CPM etc.) Please be specific regarding dosage amounts, frequencies and CPM settings:

Estimated length of stay: _____

Behavioral Health Organization Issues (if applicable):

Discharge Goals:

Destination/Functional (Home with or without assist, Facility, etc.):

****PLEASE FAX TO 1.800.727.0841 UPON COMPLETION OF THIS FORM****

A health plan with a Medicare contract.
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