



**BlueCross BlueShield
of Tennessee**

P.O. Box 180205
Chattanooga, TN 37402

www.bcbst.com

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**BlueAdvantage
Skilled Nursing Facility/Inpatient Rehabilitation Authorization Request Form
Fax: 1-800-255-0244**

Skilled Nursing Facility **Inpatient Rehabilitation**

Member Information

Member Name: _____ Date of Birth: _____
ID Number: _____

Facility Information

Facility Name: _____ Contact Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Provider Number: _____ Tax ID Number: _____

Provider Information

Provider Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Provider Number: _____ Tax ID Number: _____

Clinical Information

Diagnosis: _____
Height: _____ Weight: _____
Patient Level of Orientation:
 Alert and Oriented Willing and Able to Participate Can Follow Commands
Types of Discipline (Therapy): Speech Occupational Physical
Number of Hours per Day: _____
Type of Surgery: _____ Date of Surgery: _____
Pain Control (by discharge): PO IV Please specify: _____
Comorbidity: _____
Pre-Morbid Condition: _____
Home Environment:
Single or Multi Level: _____ Number of steps to enter home: _____

Number of steps within home: _____ Availability of caregiver: _____ -- include in box

Current Functional Status (DAY PRIOR TO DISCHARGE FROM ACUTE CARE FACILITY):

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association
H5884 BA-SNF/Rehab Request 9/30/2005



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	Minimum	Moderate	Maximum	Caregiver Assistance	Stand-By Assistance	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? (i.e., intravenous antibiotics, total parenteral nutrition (TPN), oxygen, continuous passive motion (CPM), etc.) Please be specific regarding dosage amounts, frequencies and CPM settings:

Behavioral Health Issues (if applicable): _____

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

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