BlueCross BlueShield of North Carolina MEDICARE

February 2024

# *Medicare Advantage Skilled Nursing Facility/Rehabilitation Precertification Worksheet*

Please note, this communication applies to Healthy Blue + Medicare[SM] (HMO-POS D-SNP) offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC).

If you are not set up on secure email, send your contact information via email, and we will contact you to assist setting up secure email.

Your request may be delayed if all requested information is not provided.

Fill out this form in your PDF viewer and send it to:

- Email (preferred): MedicareAdvantage@healthybluenc.com
- Fax: **844-211-7140** initial; **844-211-7141** concurrent

Provide a case reference number for continued stay review (CSR):

| | |
|---|---|
| Date form completed: | Click or tap to enter a date. |
| Date form sent to Blue Cross NC: | Click or tap to enter a date. |

Select which service is being requested:

| | |
|---|---|
| ☐ Skilled nursing facility (SNF) initial request | ☐ SNF CSR request |
| ☐ Acute rehabilitation initial request | ☐ Acute rehabilitation CSR request |
| Admit date to post-acute facility: Click or tap to enter a date. | |

| **Demographic Information** | |
|---|---|
| Member name: | |
| DOB: | |
| Member ID No.: | |
| Reference No.: | |
| SNF/Rehab facility name: | |
| Facility NPI No.: | |
| Facility street address, city, state, ZIP: | |
| SNF/Rehab contact name: | |
| Contact phone number/fax: | |

**https://www.bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare**

Blue Cross and Blue Shield of North Carolina Senior Health, DBA Blue Cross and Blue Shield of North Carolina, is an HMO-POS D-SNP plan with a Medicare contract and a NC State Medicaid Agency Contract (SMAC). Enrollment in Blue Cross and Blue Shield of North Carolina Senior Health depends upon contract renewal.


NCBCBS-CR-052515-24-CPN52480 March 2024

| **Demographic Information** | |
|---|---|
| MD who will follow member at SNF: | |
| MD NPI No.: | |
| MD phone number: | |
| MD street address, city, state, ZIP: | |

| **Transfer Information** | |
|---|---|
| Transfer from: | |
| Name of contact at transferring facility: | |
| Phone number of contact at transferring facility: | |
| Fax number of contact at transferring facility: | |
| Diagnosis for post-acute admission (include ICD code): | |
| Reason for skilled stay: | |
| Hospital 6 click score (if floor to SNF): | |

| **Past Medical History (PMH)**<br>Include if member had percutaneous endoscopic gastrostomy (PEG) placed <Insert Number> years ago. Report chronic conditions here. Document any daily medications that required daily monitoring and/or any wounds that need daily care. |
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| **Prior Level of Function (PLOF)**<br>This must be measurable. | |
|---|---|
| Does member ambulate? | ☐ Yes ☐ No |
| If yes, report distance: | |
| Level of assistance: | |
| Wheelchair mobility: Self-propel | ☐ Yes ☐ No |
| Transfers: | |

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| ADLs:<br>(activities of daily living) | |
| DME: | |
| Community resources already in place? (Meals on Wheels, Waiver program, etc.): | |
| **Mental Status** | |
| Baseline mental status: | |
| Current mental status: | |
| Ability to follow commands: | |
| **Home Setup** | |
| Number of steps to home: | |
| Rails? | ☐ Yes ☐ No |
| Bed first floor? | ☐ Yes ☐ No |
| Bath first floor? | ☐ Yes ☐ No |
| Is there ability for first floor setup? | ☐ Yes ☐ No |
| Member lives with: | |
| Is caregiver available 24 hours a day? | ☐ Yes ☐ No |
| If yes, is caregiver able to assist at current level of function? | ☐ Yes ☐ No |
| Family contact *Power of Attorney* (*POA*) name and phone number: | |
| **Clinical Review Initial or Concurrent** | |
| Date: | Click or tap to enter a date. |
| Nursing/medical needs: | |
| Vitals: | |
| Labs:<br>(If applicable, add any abnormal values or if being treated for medical needs.) | |

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| Medications:<br>(Include medication name, dose, frequency, route, stop date, and next MD appointment. No need to note routine meds.) | |
| Respiratory:<br>(Include $O_2$ flow. Is it new? If not new, what were they on at home? Include teaching needs, $O_2$ sats, nebulizers, date trach placed, size, suctioning frequency.) What is the goal? De-cannulation or going home with trach? | |
| GI/GU: Oral diet? | ☐ Yes ☐ No |
| Diet type: | |
| NG/PEG tube:<br>(Include date placed, what member is receiving, current rate, goal rate, weights, and how tolerating.) | |
| TPN (total parenteral nutrition):<br>(For example: access, stop date, rate, how tolerating, if they were on previously at home.) | |
| Wounds and treatment:<br>(Include stage of wound, treatment, wound measurements, drainage, frequency of dressing changes, and appointments with wound specialist.) | |
| **Physical and Occupational Therapy** | |
| Date of therapy evaluation: | Click or tap to enter a date. |
| Date of current therapy status: | Click or tap to enter a date. |
| Weight bearing status: | |
| Next ortho appointment: | |
| Ambulation: | Evaluation: |
| | Current status: |

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| Wheelchair mobility if applicable: | Evaluation:<br>Current status: |
| Bed mobility: | Evaluation:<br>Current status: |
| Transfers: | Evaluation:<br>Current status: |
| Stairs: | Evaluation:<br>Current status: |
| Balance: | Evaluation:<br>Current status: |
| Feeding: | Evaluation:<br>Current status: |
| Grooming/hygiene: | Evaluation:<br>Current status: |
| Bathing: | Evaluation:<br>Current status: |
| Dressing: | Evaluation:<br>Current status: |
| Toileting/toilet transfers: | Evaluation:<br>Current status: |
| Speech therapy: | Evaluation:<br>Current status: |
| **Discharge Information** | |
| Teaching/training on proper treatment:<br>(Include teaching that needs to be completed or that was successful or unsuccessful.) | |
| Anticipated disposition: | |

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| Barriers to discharge: | |
| Discharge plan: | |
| Estimated discharge date: | Click or tap to enter a date. |
| Care conference date/discussion: | |
| Referred to home healthcare (HHC)<br>If yes, name of company: | ☐ Yes ☐ No |
| DME needed:<br>If yes, what is needed? | ☐ Yes ☐ No |
| Community resources needed:<br>If yes, which program? | ☐ Yes ☐ No |
| Next MD appointment: | |

**Important note:** You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.