Blue Cross Community Health Plans℠

Postacute Care, Prior Authorization Form for Blue Cross Community Health Plans

Skilled Nursing Facility, Inpatient Rehabilitation Facility, Long-Term Acute Care Hospital

Submitting prior authorization requests online is preferred. Refer to **Authorizations & Referrals** for information on how to access Medicaid Authorizations via Availity® Essentials.

☐ Initial ☐ Concurrent

If you don't have online access, you may use this form when submitting requests for prior authorization of SNF, IRF or LTACH services for members with **BCCHP**℠.

- Enter your information on this electronic document to ensure legibility.
- Answer all questions and complete all fields. Enter NA if not applicable. Save and print your completed form.
- Fax your completed form to **312-233-4060**, along with any necessary supporting clinical documentation.
- Incomplete submissions will be returned unprocessed.

If you have questions, call customer service for BCCHP at **877-860-2837**. Prior authorizations, including precertifications and recertifications, are not a guarantee of payment. The facility and provider must participate with the local Blue Plan or the member may incur higher costs.

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
Are all therapy notes within 24-48 hours of admission date?	☐ Yes	☑ No
Is SNF member receiving at least one hour of therapy five days a week?	☐ Yes	☑ No
Is IRF member receiving PT or OT at least three hours daily, five days per week and able to sit for one hour per day?	☑ Yes	☐ No
Is the three-day waiver being utilized?	☐ Yes	☑ No
Sign and date here:		

Documents to attach:

- ☐ History and 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 and Coverage

Facility type: ☑ SNF ☐ IRF ☐ LTACH	Estimated (number of days):
Admitting diagnosis:	ICD-10 code:

Member Information

Member name:	**Date of birth:**	**Subscriber ID and Medicaid Recipient Identification Number:**
Member's primary address:	**Member phone number:**	

Member Information

Primary caregiver:
- ☐ Spouse
- ☑ Child
- ☐ Self
- ☐ Friend
- ☐ Paid Caregiver

Primary caregiver name and phone number:
Nane and phone number

Residence prior to hospital admission:
- ☐ Lives alone
- ☐ Lives with family
- ☐ Lives with paid caregiver
- ☐ Lives in a shelter
- ☐ Homeless
- ☐ Assisted living facility
- ☐ Long-term care or nursing home

Primary language:	**Advanced directive:** ☐ Yes ☐ No	**DNR status:** ☐ Yes ☐ No

Facility Information

Admission date:	**Submitting facility name:**	
Submitting facility National Provider Identifier:	**Submitting facility phone number:**	
Submitting facility phone number:		
Servicing facility name:	**Servicing facility NPI:**	**Servicing facility address:**
Servicing facility phone number:	**Servicing facility fax number:**	**Servicing facility contact name:**

Admission Information

Expected date of admission:	**Admitting diagnosis and ICD-10 code:**	
Admitting physician (first name, last name):	**Admitting physician NPI:**	
Admitting physician address:	**Admitting physician phone number:**	
Servicing facility phone number:	**Servicing facility fax number:**	**Servicing facility contact name:**

Medical history:

Risk factors:
- ☐ Smoker
- ☑ Dementia
- ☐ Chronic Pain
- ☑ # of falls <90 days
- ☐ None
- ☐ Alcohol abuse
- ☐ Urinary incontinence
- ☐ Recent amputation
- ☐ Multiple medications
- ☐ Other:

Significant surgical history and dates:

Complications:

Additional notes:

Clinical Information

Height:	**Weight:**	**Vital signs:** TEMP	HR RR BP
Isolation precautions:	☐ No	☐ Yes	*If yes, please specify:*

Sensory status: ☐ Alert and oriented ☐ Confused ☐ Deaf ☐ Blind ☐ Ability to Speak
☐ Unable to read ☐ Ability to follow simple commands

Diet: ☐ NPO ☐ Regular ☐ Soft ☐ Mech. Soft ☐ Puree ☐ Liquid **Other:**

Tube feeding: ☐ No ☐ Yes *If yes, please specify:*

Bowel: ☐ Continent ☐ Incontinent **Bladder:** ☐ Continent ☐ Incontinent

Catheter Type:

Respiratory: 02 Sat: ☐ Room air ☐ On 02 **02 delivery:** ☐ None Type:

Resp tx: ☐ Yes ☐ No **Frequency and type:**

Trach: ☐ Yes ☐ No

Vent: ☐ Yes ☐ No **Settings:**

Suction: ☐ Yes ☐ No **Number every 24 hours:**

Route: ☐ Nasal ☐ Trach ☐ Oral

Pain location:

Pain scale: ☐ Before medication ☐ After medication

Skin status: **Intact** ☐ Yes ☐ No

If not intact, complete fields below and attach additional information as necessary.

Wound or incision location and stage:	**Size: LxWxD (CM):**	**Treatment:**

Medications

List significant medication changes at reassessment:

IV or PICC line: ☐ No ☐ Yes If yes, list IV medications below

Medication	Route	Dose	Frequency	Start date	End date

Mobility and Functional Status (Prior level of functioning at home)

Ambulation:
Number of feet:

Assist device used: ☐ No ☐ Yes If yes, please specify

Ability to perform ADLs: ☐ Dependent ☐ Max. assist ☐ Mod. assist ☐ Min. assistance ☐ Independent ☐ CGA ☐ SBA

Ability to perform IADLs ☐ Dependent ☐ Max. assist ☐ Mod. assist ☐ Min. assist ☐ Independent ☐ CGA ☐ SBA

PT and OT

Date of PT and OT Notes: **BIMS or CPS Score:** **Weight bearing status:**

PT goals:

OT goals:

Mobility and Functional Status (Current level of functioning)

Ambulation:
Number of feet:

Assist device used: ☐ No ☐ Yes If yes, please specify

Ability to Perform ADLs: ☐ Dependent ☐ Max. assist ☐ Mod. assist ☐ Min. assist ☐ Independent ☐ CGA ☐ SBA

Ability to Perform IADLs: ☐ Dependent ☐ Max. assist ☐ Mod. assist ☐ Min. assist ☐ Independent ☐ CGA ☐ SBA

For the following areas, please use the number that correlates to the level of function of the patient:

1. Dependent
2. Substantial or maximal assistance
3. Partial or moderate assistance
4. Supervision or contact guard assistance
5. Setup or cleanup assistance
6. Independent
7. Resident refused
8. Not attempted
9. Not applicable
10. Not attempted due to environmental conditions

Eating:	Oral hygiene:	Toileting hygiene:	Toilet transfer:
Telephoning:	Dressing (UE):	Dressing (LE):	Bathing (UE):
Bathing (LE):	Bed mobility:	Transferring:	Stairs:
Sit to stand:	Walk 10 feet:	Walk with turns:	Gait assistance:

Speech Therapy

Current therapy status:	☐ None	☐ Dysphagia evaluation or modified barium swallow
Results, aspiration risk, recommendations:		

Speech impairments:	☐ Yes	☐ No	**Cognitive impairments:**	☐ Yes ☐ No
Currently receiving SLP services?	☐ Yes	☐ No	*If yes, select all SLP related co-morbid conditions that apply below*:	

☐ Apraxia	☐ Dysphagia	☐ ALS	☐ Oral cancers
☐ TBI	☐ Trach care	☐ Ventilator	☐ Respirator
☐ Laryngeal cancer	☐ Speech and language deficits	☐ Aphasia: VCA, TIA, stroke	☐ Hemiplegia or hemiparesis

Swallowing disorder?	☐ No	☐ Yes	*If yes, select all that apply:*
☐ Loss of liquids or solids from mouth when eating or drinking.		☐ Holding food in mouth or cheeks or residual food in mouth after meals.	
☐ Complaints of difficulty or pain with swallowing		☐ Coughing or chocking during meals or when swallowing medications	

Discharge Plans (Must be initiated upon admission)

Discharge date (tentative):			**Home evaluation date:**	
Discharge location:				
☐ Home alone	☐ Home with family		☐ HHC company:	
☐ Assisted living	☐ Long-term care		☐ Other:	
Home evaluation date:				
Number of levels:	☐ One	☐ Two	☐ Three	☐ Other
Number of steps at:	Entry		Bed	Bath
Equipment needs:				
Supervision needs:				
Discharge barriers:				