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MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Initial Precertification Form for SNF/Rehab/LTCH

Please complete all pages and fax to a number below.

Commercial members: **1-888-641-5330**

Medicare Advantage members: **1-800-205-8885**

Federal Employee Program members (Prefix R): **1-800-205-8885**

BCBSMA employees: **1-617-246-4299**

Use this form to request authorization (or initial precertification) for skilled nursing, long-term care hospital, or rehabilitation hospital services. To request recertification of an existing request, please use our SNF/Rehab/LTCH Clinical Recertification Request Form.

Do not use this form to request authorization for physical, occupational, or speech therapy for members in long-term care. For authorization instructions for these services, log in to Provider Central and go to **Clinical Resources> Prior Authorization>Outpatient Rehabilitation Therapy**.

Section A. Member Information			
Member name:		Date of birth (mm/dd/yyyy):	
Blue Cross Blue Shield of MA member ID number:		Date of evaluation (mm/dd/yyyy):	

Section B. Facility Information			
Facility referred to:			
Address:			
Contracted with local BCBS?	☐ Yes ☐ No	Facility NPI:	
Facility phone #:		Facility fax #:	
Facility attending MD:		Facility attending MD NPI:	
Facility attending MD phone #:		Facility attending MD fax #:	
Facility attending MD address:			
Acute facility:			
Acute attending MD:			
Acute attending MD phone #:		Acute attending MD NPI:	
Place of service requested:	☐ SNF/TCU ☐ Acute Rehab ☐ LTCH/Chronic		

Ambulance services reminder. Members requiring ambulance services must be transported by a Blue Cross Blue Shield of Massachusetts-participating ambulance provider. To find an in-network ambulance provider, please use Find a Doctor & Estimate Costs (**bluecrossma.com/findadoctor**).

Section C. Admission Information			
Facility anticipated admit date:		Requested number of days:	☐ 7 ☐ 10
Facility case manager:		Acute case manager:	
Facility case manager phone #:		Acute case manager phone #:	
		Acute case manager fax #:	

Section D. Clinical Information	
Diagnosis:	
Review of acute care admission:	
Past medical history:	
Social history:	

Member name:		BCBSMA ID #:		Date of birth:	

Section E. Clinical Status/Treatment

☐	Alert & oriented		☐	Pain:		/10	☐	Isolation		
☐	Able to follow commands		☐	Able to participate in treatment						
	T:		P:		R:			BP:		
☐	02	Sat:		%		☐	Nebs	Freq:		x/day
☐	Trach									
☐	Vent	FI02:		Peep:		☐	Vent wean	☐	Decannulation	
☐	Suctioning	Freq:		x/day						
☐	Wound	Stage/type:				☐	Dressing type:			
	Length:		Width:		Depth:		Dressing change freq:		x/day	
☐	Enteral Feeds.	% Total daily calories:		%						
☐	TPN/PPN			☐	Rate:		cc/h		x/day	
☐	IV Therapy			☐	Rate:		cc/h		x/day	

Section F. Labs/Diagnostics

WBC:		Neutrophils:		Hgb:		Hct:	
PLT:		PT:		PTT:		INF:	
Na:		K:		Glucose:		BUN/Creat:	

Other labs:		☐	Cardiac monitoring
Other tests:		☐	Chest X-ray Stable/Improving

Section G. Current Level of Function/Treatment

	Independent	Supervision	Contact guard	Min. Asst	Mod Asst.	Max Asst.	Dep.
ADL							
Bed Mobility							
Transfers							
Ambulation							

Walking distance (in feet):					Device:	☐ Cane ☐ Walker ☐ Wheelchair	
					Endurance:	☐ Good ☐ Fair ☐ Poor	
☐	PT	Frequency:		x Hrs/Day:		x Days/Week:	
☐	OT	Frequency:		x Hrs/Day:		x Days/Week:	
☐	ST	Frequency:		x Hrs/Day:		x Days/Week:	

Section H. Prior Level of Function/Treatment

	Independent	Supervision	Contact guard	Min. Asst	Mod Asst.	Max Asst.	Dep.
ADL							
Bed Mobility							
Transfers							
Ambulation							

Walking distance (in feet):		Device:	☐ Cane ☐ Walker ☐ Wheelchair
		Endurance:	☐ Good ☐ Fair ☐ Poor

Member name:		BCBSMA ID #:		Date of birth:	

Section I. Discharge Plan/Goals (including social barriers and concerns)

MPC-010419-2F (rev. 2/19)