

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, visit our Outpatient Rehabilitation Services pages on Provider Central.

Section A. Mei	mber Informat	ion					
Me	mber name:		Г	Date of birth (mm/dd/yyyy):			
Blue Cross Blue Shield of MA member ID number:		Date of evaluation (mm/dd/yyyy):					
Section B. Fac	ility Informati	- n					
	ility Information	on 					
Fac	ility referred to:						
	Address:						
Contracted wi	th local BCBS?	o Yes o No		Facility NF	PI:		
F	acility phone #:			Facility fax	#:		
Facility	attending MD:			Facility attending MD NF	PI:		
Facility attending	g MD phone #:			Facility attending MD fax	#:		
Facility attendir	g MD address:						
	Acute facility:						
Acute	attending MD:			Г			
Acute attending	g MD phone #:		Acute attending MD NPI:				
Place of ser	vice requested:	○ SNF/TCU ○ Acute Rehab ○ LTCH/Chronic					
Shield of Massachuse	etts-participating		To find	rvices must be transported l an in-network ambulance pr			
Section C. Ad	mission Inforr	nation					
Facility anticipated	admit date:		R	equested number of days:	0 7 0 10		
Facility cas	se manager:			Acute case manager:			
Facility case manag	ger phone #:		Acu	te case manager phone #:			
			,	Acute case manager fax #:			
Continue D. Clin	is al lufa masti						
	nical Informati	on					
Diagnosi							
Review of acute ca admission							
Past medical histor	y:						
Social histor	y:						

•	mber nam	e:			BC	BSM	IA ID #:				Date	of birth	n:	
Section E. Clinical Status/Treatment														
	ction E.		al Sta	atus/Tre					44.5					
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	ther labs:							 Cardiac monitoring Chest X-ray Stable/Improving 						
Other tests:						_		Ct-	able/Improv	ina				
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Se		Currer	nt I e	vel of F	unctio	n/Tr	reatme		Chest X-	ray Sta	abie/improv	irig		
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Se	ction G.	Curren		vel of F		1	reatme	nt	Min. Ass		od Asst.	Max A	sst.	Dep.
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AD Bed Tra	ction G. L d Mobility	1		1		1		nt					sst.	Dep.
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Member name:	BCBSMA ID #:	Date of birth:	
Section I.	Discharge Plan/Goals (including socia	ll barriers and concerns)	

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