Print Clear form

MASSACHUSETTS

RECERTIFICATION FORM FOR SNF/REHAB/LTCH

Please complete all pages and fax to a number below.
Commercial members: **1-888-641-5330** BCBSMA employees: **1-617-246-4299**
Medicare Advantage members: **1-800-205-8885** Federal Employee Program members (Prefix R): **1-800-205-8885**

Use this form to request recertification for long-term care hospital, rehabilitation hospital, or skilled nursing services.

Policy reminder. When care for a member receiving treatment in your facility is needed beyond the date approved at their admission, we must receive your request **48 hours** before the member is scheduled to be discharged.

Section A. Member & Facility Information

Member name:		Date of birth (mm/dd/yyyy):	
Blue Cross Blue Shield of MA member ID number:		Date of evaluation (mm/dd/yyyy):	
Facility name:			
Facility fax:			
Facility NPI:		Requested # of days:	☐ 5 ☐ 7 ☐ 10
Contact name:		Contact phone #:	
Admit date:		Discharge date:	

Section B. 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 C. 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

Member name:		BCBSMA ID #:		Date of birth:	

Section D. 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	
[redacted]					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 E. Discharge Plan/Goals (including social barriers and concerns)

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 F. Discharge Plan

Anticipated discharge date:	
Discharge to:	☐ Acute Rehab ☐ SNF ☐ Home ☐ Hospice
Anticipated discharge needs:	☐ VNA ☐ HHA ☐ PT ☐ OT ☐ ST ☐ DME
Medicaid app initiated?	☐ Yes ☐ No

MPC-022519-2J (rev. 9/22)