



Recertification Form for SNF/Rehab/LTCH

Please complete both pages and fax to a number below.

Commercial members: 1-888-641-5330

Federal Employee Program members

Medicare Advantage members:

(Prefix R): 1-800-205-8885

1-800-205-8885

BCBSMA employees: 1-617-246-4299

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 NPI:		Requested # of days:	<input type="checkbox"/> 5 <input type="checkbox"/> 7 <input type="checkbox"/> 10
Contact name:		Contact phone #:	
Admit date:		Discharge date:	

Section B. Clinical Status/Treatment											
<input type="checkbox"/>	Alert & oriented	<input type="checkbox"/>	Pain:		/10	<input type="checkbox"/>	Isolation				
<input type="checkbox"/>	Able to follow commands	<input type="checkbox"/>	Able to participate in treatment								
	T:		P:		R:		BP:				
<input type="checkbox"/>	O2	Sat:		%		<input type="checkbox"/>	Nebs	Freq:	x/day		
<input type="checkbox"/>	Trach										
<input type="checkbox"/>	Vent	FI02:		Peep:		<input type="checkbox"/>	Vent wean	<input type="checkbox"/>	Decannulation		
<input type="checkbox"/>	Suctioning	Freq:		x/day							
<input type="checkbox"/>	Wound	Stage/type:				<input type="checkbox"/>	Dressing type:				
	Length:		Width:		Depth:		Dressing change freq:		x/day		
<input type="checkbox"/>	Enteral Feeds.	% Total daily calories:		%							
<input type="checkbox"/>	TPN/PPN		<input type="checkbox"/>	Rate:		cc/h		x/day			
<input type="checkbox"/>	IV Therapy		<input type="checkbox"/>	Rate:		cc/h		x/day			

Section C. Labs/Diagnostics							
WBC:		Neutrophils:		Hgb:		Hct:	
PLT:		PT:		PTT:		INF:	
Na:		K:		Glucose:		BUN/Creat:	

Other labs:		<input type="checkbox"/>	Cardiac monitoring
Other tests:		<input type="checkbox"/>	Chest X-ray Stable/Improving

Member name:		BCBSMA ID #:		Date of birth:	
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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:		<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair	
				Endurance:		<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
<input type="checkbox"/>	PT	Frequency:		x Hrs/Day:		x Days/Week:	
<input type="checkbox"/>	OT	Frequency:		x Hrs/Day:		x Days/Week:	
<input type="checkbox"/>	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:	<input type="checkbox"/> Acute Rehab	<input type="checkbox"/> SNF	<input type="checkbox"/> Home	<input type="checkbox"/> Hospice			
Anticipated discharge needs:	<input type="checkbox"/> VNA	<input type="checkbox"/> HHA	<input type="checkbox"/> PT	<input type="checkbox"/> OT	<input type="checkbox"/> ST	<input type="checkbox"/> DME	
Medicaid app initiated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					

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