

## SKILLED NURSING FACILITY MEDEX LEVEL OF CARE FORM

Send your completed forms to: Blue Cross Blue Shield of Massachusetts 25 Technology Place, Mail stop 03/02 Hingham, MA 02043

Fax: 617-246-4210

Please use this form only for Blue Cross Blue Shield of Massachusetts Medex members who have exhausted their 100-day skilled nursing facility (SNF) benefit. Continued treatment at your SNF for a skilled level of care must meet Centers for Medicare & Medicaid Services guidelines. For questions, please call **617-246-4159**.

It is not necessary to send the member's medical record.

Facility/provider name: Provider NPI: Member name: Member ID (include prefix):    CENERAL INFORMATION	MEMBER AND PROVIDER INFORMATION									
Provider NPI:  Member name:  Member ID (include prefix):  GENERAL INFORMATION  1. Date of prior hospital stay										
Member name:  Member ID (include prefix):  GENERAL INFORMATION  1. Date of prior hospital stay	Faci	lity/provider name:								
Member ID (include prefix):  GENERAL INFORMATION  1. Date of prior hospital stay	Prov	rider NPI:								
1. Date of prior hospital stay	Men	nber name:								
1. Date of prior hospital stay	Men	nber ID (include prefix):								
1. Date of prior hospital stay	OFWER									
2. Primary diagnosis 3. Date of SNF admission: 4. Start date of Medicare coverage: 5. End date of Medicare coverage (when 100 days have exhausted): 6. Billing period* From: Through:  * Submit this form every 60 days for ongoing authorization. For retroactive reviews, please fax or call.  SKILLED NURSING SERVICES  Please complete sections below for services the member is receiving.  1. Diet:    Nasogastric   Gastrostomy   Syringe feeding   Comments:   2.   Intravenous therapy:   Comments:   3.   Vital sign changes in the past two weeks:   Comments:	GENERAL INFORMATION									
3. Date of SNF admission: 4. Start date of Medicare coverage: 5. End date of Medicare coverage (when 100 days have exhausted): 6. Billing period* From: Through:  * Submit this form every 60 days for ongoing authorization. For retroactive reviews, please fax or call.  SKILLED NURSING SERVICES  Please complete sections below for services the member is receiving.  1. Diet:    Nasogastric   Gastrostomy   Syringe feeding Comments:	1.	Date of prior hospital stay	Admission: Discharge:							
4. Start date of Medicare coverage:  5. End date of Medicare coverage (when 100 days have exhausted):  6. Billing period* From: Through:  * Submit this form every 60 days for ongoing authorization. For retroactive reviews, please fax or call.  SKILLED NURSING SERVICES  Please complete sections below for services the member is receiving.  1. Diet:    Nasogastric	2.	Primary diagnosis								
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1. Diet:  □ Nasogastric □ Gastrostomy □ Syringe feeding  Comments:  2. □ Intravenous therapy:  Comments:  3. □ Vital sign changes in the past two weeks:  Comments:	Plea	se complete sections belo	ow for services the member is receiving.							
Comments:  2. Intravenous therapy: Comments:  3. Vital sign changes in the past two weeks: Comments:		-	<b>.</b>							
2. Intravenous therapy: Comments:  3. Vital sign changes in the past two weeks: Comments:		□ Nasogastric □ Gas	strostomy							
Comments:  3. Uital sign changes in the past two weeks: Comments:		Comments:								
3. □ Vital sign changes in the past two weeks:  Comments:	2.	□ Intravenous therapy:								
Comments:										
	3.	<u> </u>								
4. Catheter:										
	4.									
□ Foley □ Suprapubic □ Urostomy			rapubic Urostomy							
Comments:	_									
5. Colostomy/lleostomy:  Comments:	ວ.	I I DIOSTOMIJIJOOSTOMIJ'								

Member name: Member ID:								
6.	Respiratory therapy:  ☐ O2-L via mask ☐ O2-L via nasal cannula		Comments (tr	eatment method an	d frequency)			
		<ul><li>□ Nebulizer</li><li>□ Chest PT</li><li>□ Trach care</li></ul>						
		Oximetry						
		Suctioning						
7.	Wou	_						
		Pressure		Vascular	☐ Diabetion	culcers		
		ments (where, ho						
8.	many <b>Pain</b>	many, stage, treatment):		 nents				
0.		Acute	Com	Herits				
	_	☐ Chronic						
		□ End of life						
9.	Othe	r skilled nursing						
•		rvations?						
SKILLE	D REH	ABILITATION SERVIC	ES					
Chec	k all th	nerapies that app	ly.					
		Frequency						
	PT							
	ST							
	ОТ							
Treatment goals (include restorative care):								
PT/ST/OT progress:								
,	., .	p 9						
CONTA	CT INF	ORMATION AND SIGN	ATURE					
Forn	n com	pleted by:						
Signature:								

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