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MASSACHUSETTS

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.

MEMBER AND PROVIDER INFORMATION

Facility/provider name:	
Provider NPI:	
Member name:	
Member ID (include prefix):	

GENERAL INFORMATION

1.	Date of prior hospital stay	Admission:		Discharge:	
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:
4. **Catheter:**
   - ☐ Foley ☐ Suprapubic ☐ Urostomy
   - Comments:
5. ☐ **Colostomy/Ileostomy:**
   - Comments:

Member name: Member ID:

6. **Respiratory therapy:**

	Comments (treatment method and frequency)
☐ O2-L via mask	
☐ O2-L via nasal cannula	
☐ Nebulizer	
☐ Chest PT	
☐ Trach care	
☐ Oximetry	
☐ Suctioning	

7. **Wounds:**

☐ Pressure ☐ Vascular ☐ Diabetic ulcers

Comments (where, how many, stage, treatment):

8. **Pain:**

	Comments
☐ Acute	
☐ Chronic	
☐ End of life	

9. Other skilled nursing observations?

SKILLED REHABILITATION SERVICES

Check all therapies that apply.

	Frequency
☐ PT	
☐ ST	
☐ OT	

Treatment goals (include restorative care):

PT/ST/OT progress:

CONTACT INFORMATION AND SIGNATURE

Form completed by:

Signature:

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