MASSACHUSETTS

SKILLED NURSING FACILITY MEDEX LEVEL OF CARE FORM

Send your completed forms to:
Blue Cross Blue Shield of Massachusetts
Medical Records
One Enterprise Drive, Mail stop 02/06
N. Quincy, MA 02171-1748
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:

Member name: ______ Member ID: ______

5. ☐ **Colostomy/Ileostomy**
   Comments: ______

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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