



MASSACHUSETTS

# SKILLED NURSING FACILITY MEDEX LEVEL OF CARE FORM

Send your completed forms to:  
Blue Cross Blue Shield of Massachusetts  
Medical Records  
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.**

- Diet:**  
 Nasogastric       Gastrostomy       Syringe feeding  
Comments:
- Intravenous therapy**  
Comments:
- Vital sign changes in the past two weeks**  
Comments:
- 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):

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8. **Pain:**

- Acute
- Chronic
- End of life

Comments


9. Other skilled nursing observations?

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**SKILLED REHABILITATION SERVICES**

Check all therapies that apply.

	Frequency
<input type="checkbox"/> PT	<input type="text"/>
<input type="checkbox"/> ST	<input type="text"/>
<input type="checkbox"/> OT	<input type="text"/>

Treatment goals (include restorative care):

PT/ST/OT progress:


**CONTACT INFORMATION AND SIGNATURE**

Form completed by:

Signature: \_\_\_\_\_

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