

Providers must request authorization for initial admissions and recertification of admissions for rehabilitation centers (rehab), skilled nursing (SNF) and long term acute care (LTAC) services. Providers are required to complete an Admission and Recertification Request Form, which is part of this speed guide. You may also download a copy of the form under the “Forms for Providers” section of the Provider page of our website at www.bcbsla.com. Use the following information to help you complete the Admission and Recertification Request form.

1 Please check the box that best describes your request.

Please Choose One:

- Admission Request
 Recertification Request

Admission Request – A request for authorization for a patient initially being admitted to a facility for treatment.

Recertification Request – An extension request of the initial admission authorization. This request must be within 24-hours prior to expiration of approved admission period.

2 Please check the type of admission for your request.

<u>Please Choose One:</u>			
Admission Type:	<input type="checkbox"/> Rehab	<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> LTAC

Rehabilitation Center (Rehab)

Provides a comprehensive array of restoration services for the physically-disabled and all support services necessary to help patients attain their maximum functional capacity.

Skilled Nursing Facility

Provides skilled nursing and/or skilled rehabilitation services to patients who need a skilled level of medical care.

Long Term Acute Care (LTAC)

Provides nursing care and related services for individuals who require medical, nursing, rehabilitation or sub-acute care services for an extended period of time.

3 Submission of the Admission and Recertification Request form must be legible and properly completed in order to be considered. Do not attach or send the patient’s entire medical record. Medical records will be requested as needed.

4 Member Information: Please provide the member’s name, date of birth and Blue Cross member identification number. If the member also has other insurance, please include other insurance coverage carrier’s name and policy number. *(All information should be provided exactly as it appears on the member’s ID card, including any prefixes or suffixes.)*

5 Requestor Information: Please provide the name of the admitting facility along with the name and phone number of the key contact person at the facility. Also provide the name of the admitting physician along with the name and phone number of the key contact person for the admitting physician’s office.

6 Clinical Information: Please provide applicable clinical information as requested on the form (front and back). Please provide any current physical, occupational and speech therapy notes that may apply.

7 Discharge Plan: Please provide plan of discharge, including name and contact information of caregiver to be used upon discharge.

8 Once you’ve completed the form, **please fax to 1.800.267.6548, ATTN: Case Management Unit.** If you have any questions, please call the Case Management Unit at 1.800.317.2299.



Phone: (800) 317-2299 Fax: (800) 267-6548

**Submit all Recertification Requests at least
24 hours prior to end of approval period.**

Please Choose One:

- Admission Request
- Recertification Request

Date Submitted: _____

Submit form to obtain authorization. Additional documentation should be attached only if it provides information not on this form pertinent to the review request. Do not attach or send patient's entire medical record. All items must be legible and properly completed.

<u>Please Choose One:</u>			
Admission Type:	<input type="checkbox"/> Rehab	<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/> LTAC

MEMBER INFORMATION:

Last Name: _____ First Name: _____ MI: _____ DOB: _____ Member Number: _____

Other Insurance Coverage Carrier: _____ ID number: _____

REQUESTOR INFORMATION:

Admitting Facility: _____ Contact Name: _____ Contact Ph. Number: _____

Admitting Physician Name: _____ Contact Name: _____ Contact Ph. Number: _____

CLINICAL INFORMATION:

Estimated Admission/ Admission Date: _____ Estimated Length of Stay: _____

Request Level of Care: _____ Admission Diagnosis code(s): _____

Presenting Signs/Symptoms or Clinical Status: _____

Admission Goals/Treatment Plan: _____

Abnormal Findings: _____

Vital Signs: _____

Physical Activity

- Independent Yes No
- Maximum Assist Yes No
- Moderate Assist Yes No

- Trach Yes No
- Foley Yes No
- Drains Yes No

Mental Status

- Oriented x 1 Yes No
- Oriented x 2 Yes No
- Oriented x 3 Yes No

- Confused Yes No
- Peg Tube Yes No
- Chest Tube Yes No
- NG Tube Yes No

Other (please specify): _____

If member is currently receiving physical, occupational and/or speech therapy, please attach current therapy notes.

~Over~

Vent Settings: _____

Attempted to wean Yes No

Respiratory Status/Treatments

O2 Requirements: _____

Suctioning: _____ Nebulizer tx's: _____

Wound Care – type of wound(s): _____

Location of wound(s): _____

Descriptions of wound(s): _____

Frequency of wound care: _____

Diet: Regular Special

IV Fluids: _____

IV Medications: _____

PO Medications: _____

Procedures: _____

EKG/EEG: _____

Lab Results: _____

Radiology: _____

DISCHARGE PLAN:

- Home alone
- Home with home health
- Home with DME
- Home with Outpatient Services
- Rehab
- Skilled Nursing Facility
- Nursing Home
- Hospice

Potential barriers to discharge plan: _____

Additional Comments/Notes: _____

Upon discharge, supply caregiver information:

Name: _____

Contact Information: _____

Form should be completed and faxed to (800) 267-6548, ATTN: Case Management Unit