CLEAR FORM

BlueCross BlueShield Kansas

# Skilled Nursing Facility and Inpatient Rehabilitation Assessment Form

☐ **Please Expedite***

Justification for Expedited Request:

If no justification given, request will be processed as standard

**Submit requests to:**
Fax: 877-218-9089
Phone 800-325-6201

*Please ONLY check this option if the provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy (CMS definition)

## 1. Member Information & Background

Patient Name: _____

Member/Patient ID Number:_____

Patient DOB:_____Pt. phone: _____

Patient Address: _____

_____

ICD-10 Code(s):_____

CPT Code(s):_____

Date of Admission: _____ ☐ TBD

Type: ☐ Inpatient Rehab ☐ SNF

# Visits/Units/Days:_____

Authorization Date Span:_____-_____

Previous auth # (if applicable):_____

Requesting Provider: _____

Requesting Provider NPI#:_____

Treating Provider:_____

Treating Provider NPI#: _____

Admitting Provider: _____

Admitting Provider NPI#:_____

Servicing Facility:_____

Svc Facility NPI#: _____

Facility Reviewer Name: _____

Phone #: _____ Fax #: _____

Admitting diagnosis with summary of acute hospital admission:

Past Medical History:

Surgical/Procedures and Dates:

**This form must be filled out completely. Chart notes are required and need to be submitted with this request. Incomplete requests will be returned to the requester.**

**CLEAR PAGES 2-5**

Member Name: _____
Member ID: _____

Today's Date:_____

☐ Initial Assessment
☐ Reassessment Last approved date: _____

**Chart notes are required to be submitted with this request, including:**

- **Hospital admission H&P**
- **Therapy notes (PT/OT/ST/wound)**
- **Care coordination notes to include social worker notes.**

**For SNF members, fax a signed/dated NOMNC form prior to member discharge.**

## 2. Clinical Information

Height: _____ Weight: _____
BP: _____ HR: _____
Respiratory Rate: ____ Temperature: _____
Pulse ox:_____% NC / Liters: _____
A & O x: ☐ x1 ☐ x2 ☐ x3 ☐ x4
☐ Tracheostomy ☐ CPAP ☐ BiPAP
Type:_____ Size: _____
Suction Freq: _____
Color & Amount: _____
Respiratory Tx: ☐ Yes ☐ No _____

Diet: ☐ NPO ☐ Oral ☐ TF ☐ TPN
Rate/Frequency/Type: _____
Bladder: ☐ Incontinent ☐ Catheter _____
Bowel: ☐ Incontinent ☐ Ostomy_____
Dialysis: ☐ Yes ☐ Acute ☐ Chronic
☐ Hemodialysis ☐ Peritoneal Dialysis
Dialysis Access: _____ Freq/Days: _____
Pain Location: _____
Pain Treatment: _____

## 3. Medications

IV medications, with ending dates:

Vascular Access/Central lines:

Significant medications that affect functioning:

Member Name: _____
Member ID: _____

## 4. Skin

Skin Intact? ☐ Yes ☐ No

Wound/Incision #1: Stage:_____

Location: _____

Wound Vac: ☐ Yes ☐ No

Size (L x W x D in cm)/Description: _____

_____

Treatment/Frequency: _____

Wound /Incision #2: Stage: _____

Location: _____

Wound Vac: ☐ Yes ☐ No

Size (L x W x D in cm)/Description: _____

_____

Treatment/Frequency: _____

*For additional wounds use section 11*

## 5. Prior Level of Function

Prior level of function ADLs: _____

Resides: ☐ Alone ☐ W/ Spouse ☐ Other _____

Support: ☐ Spouse ☐ Children ☐ Others _____

Home Description (steps to enter, levels, bed / bath location, etc.):

## 6. Key for Mobility and Self-Care Functioning

| | |
|---|---|
| **I** | Independent |
| **MI** | Modified Independent |
| **Sup** | Supervision |
| **SBA** | Standby Assist |
| **CGA** | Contact Guard Assist |

| | |
|---|---|
| **Min** | Minimal |
| **Mod** | Moderate |
| **Max** | Maximum |
| **Total** | Total Assist |

Member Name: _____
Member ID: _____

## 7. Physical Therapy

Bed Mobility: _____

Transfers: _____

Ambulation: _____

Distance: _____

Assistive Devices: _____

Stairs: _____

## 8. Occupational Therapy

Feeding: _____

Bathing (Upper Body): _____

Dressing (Upper Body): _____

Bathing (Lower Body): _____

Dressing (Lower Body): _____

Grooming: _____

Toileting / Hygiene: _____

ADL/Toilet Transfers: _____

## 9. Speech Therapy

- [ ] Dysphagia Evaluation
- [ ] Modified Barium Swallow
- [ ] Aspiration Risk

Results/Risks /Recommendations:

Member Name: _____
Member ID: _____

## 10. Discharge plans

D/C Date: _____ ☐ Tentative ☐ Actual

D/C Follow-up Appt Date: _____

D/C with: ☐ HHC Provider _____

☐ Outpatient Provider _____

☐ DME _____

Contact Person at D/C: _____

Barriers to Discharge:

Discharge To _____

Provider Name/Specialty: _____

HHC Phone: _____Fax _____

OP Prov. Ph#:_____ Fax:

DME Phone: _____ Fax:_____

Contact Phone # at D/C: _____

## 11. Additional Comments