

**Medicare Advantage**

**SNF/Rehab Pre-Cert Worksheet**

**E-mail this form to:** **OHDischargePlanning@anthem.com**

If you are not set up on secure e-mail please email us your contact information and we will contact you to assist with getting set upon secure e-mail.You can also fax this form to 877-423-9972

**Your request may be delayed if all requested information is not provided**

**Please provide case reference number for Continued Stay Review:**

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| **Date Form Completed:**  |  |
| **Date Form Sent to Anthem:** |  |

**(Please place an x in the box to show what service is being requested)**

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| **SNF Initial Request** |  | **SNF CSR Request** |  |
| **Acute Rehab Initial Request** |  | **Acute Rehab CSR Request** |  |
| **ADMIT DATE TO POST ACUTE FACILITY:** |  |

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| **Demographic Information**  | **RESPONSES:** |
| **Member Name:** |  |
| **DOB:** |  |
| **Member ID#:** |  |
| **Reference Number:** |  |
| **SNF/Rehab Facility Name:** |  |
| **Facility NPI#:** |  |
| **Facility Address, City, State, Zip:** |  |
| **SNF/Rehab Contact Name:** |  |
| **Contact Phone Number/ Fax Number:** |  |
| **MD Who Will Follow Member at SNF:** |  |
| **MD NPI#:** |  |
| **MD Phone Number:** |  |
| **MD Address, City, State, Zip:** |  |

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| **Transfer Information** |
| **Transfer From:** |  |
| **Name of Contact at Transferring Facility:** |  |
| **Phone # of Contact at Transferring Facility:** |  |
| **Fax # of Contact at Transferring Facility:** |  |
| **Diagnosis for Post Acute Admission (Include ICD Code):** |  |
| **Reason for Skilled Stay** |  |
| **Hospital 6 Click Score (if Floor to SNF):** |  |

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| **\*\*\*PMH: Put if member had PEG placed xx years ago; Chronic conditions need to be added here. Document any daily medications that required daily monitoring; Document any wounds that needed daily care\*\*** |
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| **\*\*\*Prior Level of Function (PLOF) This must be measureable\*\*\*** |  |
| **Does Member Ambulate? (Yes/No):**  |  |
| **If yes, # Feet:**  |  |
| **Level of Assistance:**  |  |
| **Wheelchair Mobility: Self-Propel (Yes/No):** |  |
| **Transfers:** |  |
| **ADL’s** |  |
| **DME:** |  |
| **Community Resources Already in Place? (Meals on Wheels, Waiver Program, etc):** |  |

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| **Mental Status** |
| **Baseline Mental Status:** |  |
| **Current Mental Status/Ability to Follow Commands:** |  |

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| **Home Set Up** |  |
| **# Steps to Home:** |  |
| **Rails (Yes/No):** |  |
| **Bed 1st Floor (Yes/No):** |  |
| **Bath 1st Floor (Yes/No):** |  |
| **Is there ability for 1st floor Set Up** |  |
| **Member Lives With:** |  |
| **Is Caregiver Available 24 Hours a Day: (Yes/No):** |  |
| **If yes, is caregiver able to assist at current level of function: (Yes/No):** |  |
| **Family Contact POA Name and Phone Number:**  |  |

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| **Clinical Review Initial OR Concurrent** |
| **Date:** |  |
| **Nursing/Medical Needs:** |  |
| **Vitals:** |  |
| **Labs (If applicable add any abnormal values or if being treated for medical needs):** |  |
| **Medications (to include medication, dose, frequency, route, stop date and next MD appointment. No need to note routine meds):** |  |
| **Respiratory:** (**to include o2 flow, is it new/if not new what were they at home, teaching needs, 02 sats, nebulizers, trach- date placed, size, suctioning frequency. What is the goal: De-cannulation or going home with trach?**) |  |
| **GI/GU: Oral Diet: (yes or no)** |  |
| **Diet Type**: |  |
| **NG/Peg Tube**: (**to include date placed, what is member receiving, current rate and goal rate, weights, how tolerating**) |  |
| **TPN**: (**Access, stop dates, rate, how tolerating, if they were on previously at home**) |  |
| **Wounds and Treatment:** (**to include stage of wound, treatment, wound measurements, drainage, frequency of dressing changes, appointments with wound specialist**) |  |

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| **Physical and Occupational Therapy** |
| **Date of Therapy Evaluation:** |  |
| **Date of Current Therapy Status:** |  |
| **Weight Bearing Status:** |  |
| **Next Ortho Appointment:** |  |
| **Ambulation:** | **Eval**:  |
| **Current Status**: |
| **Wheelchair Mobility (if applicable):** | **Eval**: |
| **Current Status**: |
| **Bed Mobility:** | **Eval**: |
| **Current Status**: |
| **Transfers:** | **Eval**: |
| **Current Status**: |
| **Stairs:** | **Eval**: |
| **Current Status**: |
| **Balance:** | **Eval**: |
| **Current Status**: |
| **Feeding:** | **Eval**: |
| **Current Status**: |
| **Grooming/Hygiene:** | **Eval**: |
| **Current Status**: |
| **Bathing:** | **Eval**: |
| **Current Status**: |
| **Dressing:** | **Eval**: |
| **Current Status**: |
| **Toileting/Toilet Transfers:** | **Eval**: |
| **Current Status**: |
| **Speech Therapy:** | **Eval**: |
| **Current Status**: |

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|  | **Discharge Information:** |
| **Teaching/Training on proper Treatment (To include teaching that needs to be completed or that was successful and/or unsuccessful**: |  |
| **Anticipated Disposition:** |  |
| **Barriers to Discharge:** |  |
| **DISCHARGE PLAN:**  |  |
| **Estimated Discharge Date:** |  |
| **Care Conference Date/Discussion:** |  |
| **Referred to HHC (Yes/No):****If yes, Name of Company:** |  |
| **DME needed: (If yes, what?)** |  |
| **Community Resources needed: (If yes, what?)** |  |
| **Next MD appointment:** |  |

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