

**Medicare Advantage**

**SNF/Rehab Pre-Cert Worksheet**

**E-mail this form to:** [**OHDischargePlanning@anthem.com**](mailto: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:**

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

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

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

|  |  |
| --- | --- |
| **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:** |  |

|  |  |
| --- | --- |
| **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):** |  |

|  |
| --- |
| **\*\*\*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\*\*** |
|  |

|  |  |
| --- | --- |
| **\*\*\*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):** |  |

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

|  |  |
| --- | --- |
| **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:** |  |

|  |  |
| --- | --- |
| **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**) |  |

|  |  |
| --- | --- |
| **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**: |

|  |  |
| --- | --- |
|  | **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:** |  |

**Protected Health Information (PHI)**

These documents contain PHI.  Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at 800-262-2731.

Providers: You are required to return, destroy or further protect any PHI you receive pertaining to patients that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

Anthem Blue Cross and Blue Shield is a Medicare Advantage Organization with a Medicare contract. For Dual-Eligible Special Needs Plans: Anthem Blue Cross and Blue Shield is a D-SNP with a Medicare contract and a contract with the State Medicaid program. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.