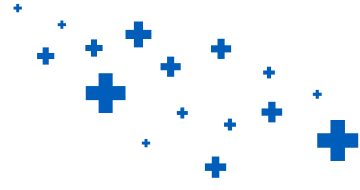
of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com



Skilled Nursing Facility/
Inpatient Rehabilitation Authorization Request
Fax: 1-866-230-3424 or 1-888-328-0394 (Commercial)

- Confidential -

Initial Request: ______________________ **Concurrent Review:** ______________________

Inpatient Rehabilitation ❑

Skilled Nursing Facility ❑ Level I ❑ Level II ❑ Level III ❑

Member Information

Member Name: ______________________ Date of Birth: ______________________

Member Identification Number: ______________________ Reference Number: ______________________

Member Current Telephone Number: ______________________

SNF / Inpatient Rehabilitation Facility Information

Expected Date of Admission to Facility:

Facility Name: ______________________ Contact Name: ______________________

Is the SNF/Inpatient Rehabilitation Facility "in network" with BlueCross BlueShield of Tennessee? Yes ❑ No ❑

Address:

Phone Number: ______________________ Fax Number: ______________________

Provider Number: ______________________ NPI Number: ______________________

Facility member is transferring from: ______________________

Ordering Physician Information

Prescribing Physician Name:

Is the Ordering Physician "in network" with BlueCross BlueShield of Tennessee? Yes ❑ No ❑

Address: ______________________

Phone Number: ______________________ Fax Number: ______________________

Provider Number: ______________________ NPI Number: ______________________

Admitting Physician Information

Facility Physician Name: ______________________

Is the Facility Physician "in network" with BlueCross BlueShield of Tennessee? Yes ❑ No ❑

Address: ______________________

Phone Number: ______________________ Fax Number: ______________________

Provider Number: ______________________ NPI Number: ______________________

Providers should obtain the above information for the online authorization process.

Clinical Information

Diagnosis: ______________________

Co Morbidity / Past Medical History: ______________________

Height: __________ Weight: __________

Type of Surgery: ______________________

Date of Surgery: ______________________

Pain Control (at discharge): PO (by mouth) ❑ IV: ❑ Please specify: ______________________

Patient Level of Orientation

Rancho Level (1-8): ______

❑ Alert and Oriented ❑ Willing and Able to Participate ❑ Can Follow Commands

Cognitive Function: ______

Types of Discipline (Therapy): ❑ Speech ❑ Occupational ❑ Physical

Number of Therapy Hours per Day: ______

Type of Surgery: ______

Functional Status Prior to Admission: ______

Home Environment:

Single or Multi Level: ______ Number of steps to enter home: ______

Number of steps within home: ______ Availability of caregiver: ______

Current Functional Status (DAY PRIOR TO DISCHARGE from Acute Care Facility)					
FIMS Score (1 - 7)	**Dependent**	**Maximum**	**Moderate**	**Minimum**	**SBA/CGA**
Eating					
Dressing					
Bathing					
Bed / Mobility					
Supine / Sit					
Sit / Stand					
Transfers					
Steps					
Ambulation					
Toileting					

Distance of ambulation / Description of gait: ______

Assistive devices used currently: ______

Wound Care description: (length, width, drainage), treatment, frequency (attach wound description and information):

Progress toward goals/Changes in Plan of Care:

Caregiver teaching/training:

If this is a Skilled Nursing Facility request, what are the other skilled needs (e.g., IV antibiotics, TPN, oxygen, CPM, Peg Tube, wound vac., etc.)? Please be specific regarding dosage amounts, frequencies and CPM settings:

Estimated length of stay: ______

Behavioral Health Organization Issues (if applicable):

Discharge Goals: ______

Destination/Functional (e.g., home with or without assist, facility, etc.): ______