

Skilled Nursing Facility/Inpatient Rehabilitation Authorization Request

Commercial/FEP: Fax: 1-866-230-3424
BlueCare Tennessee: Fax: (423) 535-7790/Phone: 1-888-423-0131
BlueAdvantage and BlueChoice Fax: 1-888-535-5243/Phone: 1-800-924-7141
CoverKids Fax: 1-800-851-2491/Phone: 1-800-924-7141

- 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 Issues (if applicable):

Discharge Goals: _____

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