BlueCare Plus
Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402-0001
bluecareplus.bcbst.com

CONFIDENTIAL INFORMATION

BlueCare Plus (HMO SNP)℠
Skilled Nursing Facility Request Fax Form

☐ Urgent ☐ Non Urgent ☐ Retro

Initial Request: _____ **Concurrent Review:** _____

Member Information

Member Name: _____ Date of Birth: _____

Member Identification Number: _____ Reference Number: _____

Member Phone Number: _____

Is Member Enrolled in CHOICES? ☐ Yes ☐ No

Is Member Enrolled in ECF CHOICES? ☐ Yes ☐ No

Does the member have a mental illness? ☐ Yes ☐ No

Does the member have an intellectual and developmental disability (IDD)? ☐ Yes ☐ No

Please list the disability or mental illness: _____

- Was Medicaid preadmission Screen and Resident Review (PASRR) Services Requested? ☐ Yes ☐ No
- Please List PASSR services that were requested:

Skilled Nursing Facility Information

Expected Date of Admission to Facility: _____

Facility Name: _____ Contact Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ Tax Identification Number: _____

Facility member is transferring from: _____

Ordering Physician Information

Prescribing Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ NPI Number: _____

Admitting Physician Information

Facility Physician Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Provider Number: _____ NPI Number: _____

Clinical Information

Diagnosis: _____

Height: _____ Weight: _____

Current Lab (e.g., hemoglobin & hematocrit, INR, PTT): _____

Has a Doppler study of the lower extremities been performed? ☐Yes ☐No ¨

If yes, date of the last Doppler study (lower extremities)?_____

Patient Level of Orientation

Rancho Level

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

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

Number of Therapy Hours per Day:_____Number of Modalities per Day:_____

Type of Surgery:_____

Date of Surgery:_____

Pain Control (by discharge): ☐ PO ☐ IV

Please specify:_____

Commorbidity/Past Medical History: _____

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)	Minimum	Moderate	Maximum	CGA	SBA	Assistive Devices
Eating						
Dressing						
Bathing						
Bed/Mobility						
Supine/Sit						
Sit/Stand						
Transfers						
Ambulation **Distance**						

Wound Care description: (length, width, drainage), treatment, frequency:

Progress toward goals/Changes in Plan of Care:

Caregiver teaching/training:

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

Behavioral Health Organization Issues (if applicable):

Discharge Goals: _____

Destination/Functional (Home with or without assist, Facility, etc.):

Retro Request:

If a Retro request, please provide explanation:

Please list the disability or mental illness:

Please Fax to BlueCare Plus Utilization Management Department upon completion of this form

Fax: 1-866-325-6698

Telephone: 1-866-789-6314