SKILLED NURSING FACILITY
Concurrent Review Precertification Form

For Concurrent Review Requests: Complete this form and fax to **800.575.4429**
Please provide supporting clinical documentation where applicable.
Call **800.298.4806** to speak with a representative.

Complete every field unless otherwise noted. Information must be legible. Place N/A if not applicable. Pre-certifications and re-certifications are not a guarantee of payment. Incomplete submissions will be returned unprocessed.

Disclaimer Statements and Attestation

- Verify eligibility and benefits prior to request. SNF benefits verified? ☐ Yes ☐ No
  If "yes", number of days available: _____.
- Is the admission a result of a motor-vehicle accident or workplace injury? ☐Yes ☐No
- All therapy notes are within 24-48 hours of admission date (initial), or 72 hours prior to LCD (concurrent)? ☐Yes ☐No
- SNF member is receiving at least one hour of therapy five days a week (only choose one answer): ☐Yes ☐No
- Has this member started receiving services for this request? ☐Yes ☐No
- Has this member already been discharged from this service? ☐Yes ☐No

Sign and Date Here: _____

Documents to Attach: History & Physical Discharge Summary (if available) Clinical Progress Notes (for recertification requests) Medication List Therapy notes, including level of participation (evaluation and last progress notes)

Assessment Type/Coverage

Facility Type: Skilled Nursing Facility	**SNF Admitting Diagnosis and ICD10 Code:**

Member/Facility Information

Member Name	**Date of Birth**	**Member Address**
Member Policy Number	**Member Phone Number**	**Admission Date**
Requesting Facility Name and NPI Number		**Requesting Facility Address**
Requesting Facility Phone Number	**Requesting Facility Fax Number**	**Requesting Facility Contact Name**
Servicing Facility Name and NPI Number		**Servicing Facility Address**
Servicing Facility Phone Number	**Servicing Facility Fax Number**	**Servicing Facility Contact Name**

Patient Information

Primary Caregiver: ☐Child ☐Spouse ☐Friend ☐Self ☐Paid Caregiver	**Contact Number:**
Residence Prior to Hospital Admission: ☐Lives alone ☐Lives with family ☐Lives with paid caregiver ☐Homeless ☐Shelter ☐Assisted living facility ☐Long-term care/nursing home	
Advance Directive: ☐Yes ☐No	**DNR Status:** ☐Yes ☐No

Admission Information

Admission Date to SNF	**Hospital Admitting Diagnosis and ICD10 Code**
Admitting Physician (last name, first name, and NPI#)	**Physician Address and Phone Number**
Significant Surgical History and Date(s)	**Complications**
Medical History	**Additional Notes/Comments**

SNF HIPPS Code: **Please indicate if there was a change in the initial HIPPS code:** ☐Yes ☐No

Has an IPA been submitted on this case? ☐Yes ☐No
If YES, please provide clinical rationale:

What PDPM clinical category does the member fall under?

Major Joint Replacement or Spinal Surgery	☐	Cancer	☐
Non-Surgical Orthopedic/Musculoskeletal	☐	Pulmonary	☐
Orthopedic-Surgical Extremities Not Major Joint	☐	Cardiovascular and Coagulation	☐
Acute Infections	☐	Acute Neurologic	☐
Medical Management	☐	Non-Orthopedic Surgery	☐

Mobility and Functional Status – Prior Level of Function (HOME)

Ambulation (in feet): _____ **Assist device used?** ☐Yes ☐No **Type:** _____

Ability to Perform ADLs (Section GG Items): ☐Dependent ☐Max Assist ☐Mod Assist ☐Min Assist ☐CGA ☐SBA ☐Independent

Therapy Goals

PT:

OT:

Mobility and Functional Status (CURRENT)

Date of PT/OT Notes:	BIMS/CPS Score:	Weight Bearing Status:

Which of the following PT & OT clinical categories does the member fall under?

Major Joint Replacement or Spinal Surgery ☐	Non-Orthopedic Surgery & Acute Neurologic ☐
Other Orthopedic ☐	Medical Management ☐

For the following areas, please use the # that correlates to the level of function of the patient:

1. **Dependent**
2. **Substantial/Maximal Assistance**
3. **Partial/Moderate Assistance**
4. **Supervision or Touching Assistance**
5. **Set-up or Clean-up Assistance**
6. **Independent**
7. **Resident Refused**
8. **Not Attempted**
9. **Not Applicable**
10. **Not attempted due to environmental conditions**

Eating:	Oral hygiene:	Toileting hygiene:
Sit to lying:	Lying to sitting on side of bed:	Sit to stand:
Chair to bed/bed to chair:	Toilet transfer:	Walk to 10 feet:
Walk 50 feet with 2 turns:	Walk 150 feet:	Stairs:

Speech

Are they currently receiving SLP services? ☐Yes ☐No

SLP Related Co-morbid Conditions: (check all that apply)

Apraxia ☐	Dysphagia ☐	ALS ☐
Oral cancers ☐	Speech and language deficits ☐	Aphasia: CVA, TIA, or stroke ☐
Hemiplegia or hemiparesis ☐	TBI ☐	Trach care ☐
Ventilator or respirator ☐	Laryngeal cancer ☐	

Is there cognitive impairment? ☐Yes ☐No

Swallowing Disorder (check all that apply): ☐Yes ☐No

Loss of liquids/solids from mouth when eating or drinking ☐	Holding food in mouth/cheeks or residual food in mouth after meals ☐
Coughing or choking during meals or when swallowing medications ☐	Complaints of difficulty or pain with swallowing ☐

Non-Therapy Ancillary (NTA)

Enter all that apply:

Nursing

Which skilled nursing care services are indicated? Clinical Characteristics: (check all that apply)

SOB when lying flat ☐	Trach, ventilator, isolation infection ☐	Quadraplegia ☐
Respiratory treatments, oxygen therapy ☐	Radiation, Dialysis ☐	Septicemia ☐
Weight loss, vomiting, fever, dehydration ☐	HIV/AIDS ☐	IV meds ☐
Indications of depression ☐	Feeding tube ☐	IV feedings ☐
Behaviors ☐	Parkinson's ☐	Walking ☐
Multiple pressure injuries/wounds ☐	Pneumonia ☐	Oral hygiene ☐
Pain management ☐	Bowel/Bladder incontinence ☐	Surgical wound ☐

Discharge Plans (must be initiated upon admission)

Discharge Date (tentative):	**Home Evaluation Date:**
DC Location: Home alone Home with family/support HHC/Company: _____ Assisted living Long-term care Adult foster care Other: _____	**Equipment Needs:**
Discharge Barriers:	**Supervision Needs:**