HIGHMARK BLUE SHIELD
REHABILITATION
PRECERTIFICATION WORKSHEET

Submission Instructions: Please print all information.

IMPORTANT! THIS REQUEST FOR AUTHORIZATION REVIEW **CANNOT** BE PROCESSED WITHOUT SUPPORTING CLINICAL DOCUMENTATION AND/OR INFORMATION – **NO EXCEPTIONS.** Requests missing clinical information **will be returned** to the requesting provider, **delaying** the review process.

Please fax completed form to the Medical Management and Policy Department: **888.676.6795**

Type of Request:

PICK ONE: **INITIAL REQUEST** ☐ **EXTENSION REQUEST** ☐

Demographic Information:

Date:	Staffing/Care Planning Date:	**Precert #:**
Member UMI Number:		Group Number:
Date of Birth:	Patient Phone #:	Patient's Sex: ☐ Male ☐ Female
Patient's Name: (Last, First, Middle Initial)		
Patient's Address: (Street, City, State, ZIP)		
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Handicap/DEP		
Verification of Benefits: ☐ **Yes** ☐ **No**		
Subscriber's Name: (Last, First, Middle Initial)	Subscriber Phone Number:	
Admitting Physician:	Physician NPI Number:	
Physician Phone Number:	Physician Fax Number:	
Physician's Address: (Street, City, State, ZIP)		
Facility Name:	Facility NPI Number:	
Facility Phone Number:	Facility Fax Number:	
Facility's Address: (Street, City, State, ZIP)		

Admission/Initial Review:

ICD10-CM Diagnosis Code: 1) 2) 3)	Med DX or Narrative: 1) 2) 3)
Procedure Code: 1) 2)	Sur. DX or Narrative: 1) 2)

Name of Prior/Transferring Hospital/Facility:		NPI #:
Date of Admission:	Estimated Length of Stay: (Days)	Discharge Date:
Contact Person:		

Contact Phone #	Contact Fax

REHABILITATION ADMISSION TOOL (fill out if initial request only)

1. Was patient evaluated by facility, either by outreach nurse or physician and date of evaluation?

2. Prior hospitalizations. (Including acute care and any previous rehabilitation admission)

3. Mental status. (Alert/Oriented)

4. Therapy schedule. (List therapies to be provided, hours per day, number of days per week)

5. Potential for Rehabilitation Program.

6. Family Education/Home Evaluation.

7. Medical status:

a. Medically Stable_____

b. Medical History_____

_____

_____

c. Medications_____

d. Height/Weight_____

e. Special Diets_____

f. Medical Care (Wounds, Respiratory, EX., IV-IM-SQ, Dialysis, Radiation, etc.)_____

_____

REHABILITATION CONCURRENT REVIEW TOOL (fill out if extension request only)

1. Medical Status

2. Medically Stable:

3. Medications:

4. Special Diets:

5. Medical Care (Wounds, Respiratory, RX, IV-IM-SQ, Dialysis, Radiation, etc.):

6. Potential for Rehabilitation Program

7. Family Education / Home Evaluation

Member's Name:	**Member's UMI #:**

The following must be provided in measurable terms.

Physical Therapy (include freq of treatments /day & /week)

Circle NA if not applicable to member treatment : NA

Ambulation:	Distance:

Device:	☐ Walker	☐ Cane	☐ Bars	☐ Roller walker
Assistance:	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision	

Stairs

Device:	☐ Crutches	☐ Canes	☐ Railing

Assistance:	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision	

Transfers

Bed

Assistance:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision		

Tub/Shower

Assistance:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision		

Car

Assistance:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision		

W/C

Assistance:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision		

Toilet

Assistance:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision		

Sit to Stand

Assistance:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision		

Motor Status

U/E Left:	AROM	Strength	**L/E Left:**	AROM	Strength
U/E Right:	AROM	Strength	**L/E Right:**	AROM	Strength

W/C

Management:	☐ Good	☐ Fair	☐ Poor
Curbs/Ramps:	☐ Good	☐ Fair	☐ Poor

Balance:	☐ Good	☐ Fair	☐ Poor
Endurance:	☐ Good	☐ Fair	☐ Poor
Safety:	☐ Good	☐ Fair	☐ Poor

Short-Term Goals:

Long-term Goals:

Member's Name:	**Member's UMI #:**

Occupational Therapy (include freq of treatments /day & /week)

Circle NA if not applicable to member treatment : NA

ADL's

Dressing: U/E-	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ Asst. Device
L/E-	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ Asst. Device
Bathing:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	
Grooming:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	
Eating:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	
Toileting:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	

Mat/Bed Mobility

Rolling: Left-	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	
Right-	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	
Supine and Sit:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	
	☐ 1 Person	☐ 2 People	☐ Supervision		

Transfers

Tub/Shower:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision		
Car:	☐ Independent	☐ Minimum	☐ Moderate	☐ Maximum	☐ C/G
	☐ 1 Person	☐ 2 People	☐ Supervision		

Short-Term Goals:

Long-term Goals:

Speech Therapy (include freq of treatments /day & /week)

Circle NA if not applicable to member treatment : NA

Oral Motor:

Articulation:

Swallowing/Dysphagia:

Auditory Processing:

Expressive Language:

Attention/Concentration:

Orientation:

Memory:

Reasoning Logic:

Speech Therapy (include freq of treatments /day & /week) *(CONT'D)*

Thought Organization:

Phonation:

Visual Acuity:

Hearing:

Member's Name:	**Member's UMI #:**
Pragmatic Language:	
Gestural Skills:	
Writing:	
Math:	
Short-Term Goals:	
Long-term Goals:	
Additional Clinical Information:	
Living Arrangements/Caregiver Availability:	
Prior Status:	
Short-Term Goals:	
Transition of Care/Discharge Plan:	
Target Discharge Date	
Discharge Medications	
Long Term Goals	
Home with MD Follow Up:	Home Health Services (specify):
SNF:	Outpatient RHB:
DME Needs:	Other:
Highmark Blue Shield Internal Use Only	
Decision: ☐ Approved ☐ Denied	Initial of Reviewer:
Review Date:	Call Back Date: