HIGHMARK BLUE SHIELD
SKILLED NURSING FACILITY
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: **800.416.9195** *(Initial Pennsylvania Requests)* **877.650.6019** *(Initial Delaware Requests)* **888.676.6795** *(Extensions of Regional SNF)*

Type of Request

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

Patient Name:		Date of Birth:	
Patient Phone #		Member UMI #:	
Physician Name:		Physician NPI #:	
Physician Address (Street, City, State, ZIP)			
Facility Name:		Facility NPI #:	
Facility Address (Street, City, State, ZIP)			
Precert. #:	Prior Hospital Stay Date:	Admission Date to SNF:	Verification of Benefits: ☐ Yes ☐ No
Request Submitted by:		Phone:	Fax:

Information should include, but is not limited to, the following:
Please note calls concerning precertification and concurrent reviews are requested to be made in the a.m.

Diagnosis Code:
Medical History:
ELOS:
Transition of Care/Discharge Plan:
Target Discharge Date:

Member Name:	**Member's UMI#:**
Home Living Arrangements/Social Situation/Caregiver Availability:	
Prior Level of Function:	
RUG/Level:	

Nursing Assessment

Mental Status:
Vital Signs:
Respiratory:
Cardiovascular:
GU:
GI:
Skin: (list sizes, appearance, drainage, wound treatments, and frequency)
Nutrition: (include parenteral feedings & weight)
Pain:
Medications: (include po,iv, sq, transdermal)
Teaching:
Additional Clinical Information (ex. Lab Results etc):

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:

Member's Name:	**Member's UMI #:**
Thought Organization:	
Phonation:	
Visual Acuity:	
Hearing:	
Pragmatic Language:	
Gestural Skills:	
Writing:	
Math:	
Short-Term Goals:	
Long-term Goals:	

Complete following section ONLY if request is for EXTENSION of services:	
Current Medical Status:	
Treatment:	
Transition of Care/Discharge Plan:	
Target Discharge Date:	
Discharge Medications:	
Home with MD Follow Up:	Home Health Services (specify):
SNF (long-term):	RHB:
DME Needs:	Other:
Specific reasons for continued service, progress, or any other pertinent info related to extension of services:	