VSHP Volunteer State Health Plan
1 Cameron Hill Circle
Chattanooga, TN 37402

BlueCare TennCareSelect

Skilled Nursing Facility/ Inpatient Rehabilitation Fax Form

Fax: (423) 535-7790

- 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: _____

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: _____

The above information should be obtained with the online authorization process.

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:

_____

Comorbidity/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.): _____

_____

****PLEASE FAX TO (423) 535-7790 UPON COMPLETION OF THIS FORM****

BlueCross BlueShield of Tennessee developed this guideline to supplement the Milliman Care Guidelines®.
Exceptions may be required to comply with EPSDT and TennCare regulations. BCBST modification effective October 1, 2011.