Medicare Advantage Skilled Nursing Facility/Rehabilitation Precertification Worksheet

Fax completed form and most recent supporting clinical documentation to 304-974-3191. Please note that your request may be delayed if all requested information is not provided.

Disclaimer: This form alone is **NOT** sufficient for appropriate review process.

Select which service is being requested	
SNF Initial Request	SNF Continued Stay Request
Acute Rehab Initial Request	Acute Rehab Continued Stay Request
Expected/Actual Admit Date:	Referral # for continued stay review:

Member Demographic Information	
Member Name:	
DOB:	
Member ID Number:	
Referral Number:	

Provider Demographic Information	
SNF/Rehab Facility Name:	
Facility NPI Number:	
Facility Street Address, City, State, Zip:	
SNF/Rehab Contact Name:	
SNF/Rehab Phone Number & Fax Number:	
MD who will follow member at SNF:	
MD NPI Number:	
MD Phone Number:	
MD Street Address, City, State, Zip:	

Transfer Information	
Transfer from:	
Contact Name:	
Phone Number:	
Fax Number:	
Diagnosis (ICD code):	
Reason for skilled stay:	PT OT SLP IV ABX Wound Care Other:

Past Medical History (PMH)

Include any previously placed G-tubes, catheters and/or central lines and date they were placed. Report chronic conditions here. Document any daily medications that required daily monitoring and/or any wounds that need daily care.

Prior Level of Function (PLOF) This must be measurable.			
Does member ambulate?	Yes	No	
If yes, report distance:	ft	Household	Community
Level of Assistance:	Independent	Partial Assist	Dependent
Wheelchair mobility: Self-propel	Yes	No	
Transfers:	Independent	Partial Assist	Dependent
ADLs:	Independent	Partial Assist	Dependent
DME: (Walker, Cane, Shower chair, Grab bars, etc.)			
Community resources already in place? (Meals on Wheels, Waiver program, etc.)			

Mental Status	
Baseline Mental Status:	
Current Mental Status:	
Ability to Follow Commands:	

Home Setup			
Number of Steps to Enter Home: Rails?		Yes	No
Number of Steps Within Home: Rails?		Yes	No
Bedroom first floor?	Yes	No	
Bathroom first floor?	Yes	No	
Is there ability for first floor setup?	Yes	No	
Member lives with:	Spouse	Family	Roommate Other:
Is caregiver available 24 hours a day?	Yes	No	
If yes, is caregiver able to assist at current level of function?	Yes	No	
Family contact *Power of Attorney (POA)* name and phone number:			

Clinical Review Initial or Concurrent	
Date:	
Nursing/Medical Needs:	
Vitals:	Temp: BP: HR: RR: SpO2: Pain:
Labs: (Abnormal values or being treated for medical needs)	
Medications: (Include med name, dose, frequency, route, start and stop dates. No need to note routine meds.)	
Respiratory: (vent, trach, suctioning, nebs, O2, etc.)	
GI/GU: (oral diet, NG/PEG tube, TPN, TF rate, catheter, ostomy, etc.)	
Wound Care: (Include stage of wound, treatment, measurements, drainage, and frequency of dressing changes.)	

Physical and Occupational Therapy (Include Distance and Level of Assistance: Min A, Mod A, etc.)	
Date of evaluation: (Current status must be from most recent 48 hours within date of authorization request.)	
Weight bearing status:	
Next ortho appointment:	
Ambulation:	

Wheelchair mobility if applicable:	
Transfers:	
Stairs:	
Balance:	
Eating:	
Bathing/Dressing:	
Toileting/toilet transfer:	
Speech Therapy:	

Discharge Information		
Teaching/training on proper treatment: (Gait training, stair negotiation, aspiration precautions, etc.)		
Anticipated disposition:		
Barriers to discharge:		
Discharge plan:		
Estimated discharge date:		
Care Conference date/discussion:		
Referred to Home Healthcare? If yes, name of company:	Yes	No
DME needed: If yes, what is needed?	Yes	No
Community resources needed: If yes, which program?	Yes	No
Next MD Appointment:		

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.