QualChoice HEALTH INSURANCE

Skilled Nursing Facility & Acute Rehabilitation Facility

Fax Assessment Form

Use this form to give us with the clinical information needed to judge the necessity of an admissions or a continued stay in a facility. Please complete each field unless otherwise noted. Information must be legible. If not applicable; place 'N/A' in the field. Incomplete submissions will be returned.

Disclaimer Statements and Attestation

- Number of SNF days available: _____
- All therapy notes are within 24-48 hours of fax request.
- SNF member received at least 1 hour of therapy, 5 days a week.
- Acute rehab member is getting OT/PT at least 3 hours per day, 5 days a week and able to sit for 1 hour a day.
- Precertification and recertification process is not a guarantee of payment.
- Form was filled out by licensed clinical personnel.
- Facility and provider must participate in network or member may incur out-of-pocket expenses.
- Eligibility and benefits were verified prior to request.

As Facility Representative, *I have read and attest to the above.*

Name (Print)_____ Signature **X**_____ Date Signed (MM/DD/YYYY):_____

Section I. Assessment Type/Coverage

Facility Type ☐ SNF ☐ Acute Rehabilitation	No. of days requested?

Section II: Member/Facility Information

Member Name (Last, First, MI)	Date of Birth (MM/DD/YYYY)	QualChoice Policy No.	Phone No.	
Member Address	City		State	Zip
Name of Hospital			Admission date (MM/DD/YYYY)	
Name of Admitting Facility		Admitting Facility NPI No.		
Admitting Facility Address		City	State	Zip
Phone No.	Fax No.	Facility Reviewer Name		

Section III. Admission Information

Admission date to SNF/IPR (MM/DD/YYYY)	Name of Admitting Doctor *(First, Last)*		Admitting Doctor NPI No.	
Admitting Doctor Mailing Address		City	State	Zip
DX Reason for Facility Admit				
Complications				
Surgical Procedure			Date (MM/DD/YYYY)	
Medical History				
Height	Weight	Prior level of function (home)	ELOS (# of days)	

Section IV. Clinical Information

Vital Signs T:_____ P: _____ R:_____ BP: _____	**Bowel** ☐ Continent ☐ Incontinent **Bladder** ☐ Continent ☐ Incontinent **Cath/Type:**_____	**Diet** ☐ NPO *or* ☐ Type:_____ **Tube Feeding** ☐ Yes ☐ No
IV/PICC Line ☐ Yes ☐ No	**O2 delivery** ☐ None *or* ☐ Type _____ Sat:_____ Vent ☐ Yes ☐ Settings: _____	**Suction frequency/24H** ☐ None *or* ☐ Frequency _____
Respiratory TX ☐ Yes ☐ No ☐ Frequency_____	**Trach** ☐ None *or* ☐ Type _____	**Pain Site** ☐ None *or* ☐ Scale & Mgmt: _____

Cognition

☐ Alert and Oriented ☐ Other _____

Medications

List significant medication changes at reassessment that affect functioning

List IV medications below with ending date.

Medication	Ending Date (MM/DD/YYYY)	Medication	Ending Date (MM/DD/YYYY)

Skin Status

Skin Status	☐ Intact. If **not** intact, complete fields below and add pages as needed
Wound or incision location & stage	
Size L x W x D (CM)	
Treatment	
Wound or incision location & stage	
Size L x W x D (CM)	
Treatment	

Mobility Current Functioning		Self-Care Functioning	
Date of PT/OT Notes		Bathing/UE	
Pre-Morbid level of functioning		Bathing/LE	
Bed mobility		Dressing/UE	
Transfers		Dressing/LE	
Gait Distance		Toileting/Hygiene mgmt.	
Gait/Assist needed		ADL transfers	

Gait/Assist device		Focus therapy goal
Stairs		
Stairs/Assist needed		
Comments		

Speech Therapy Current Status

☐ None ☐ Dysphagia evaluation/Modified barium swallow

Result/aspiration risk/recommendations

Therapy goals and associated timeline

Comments

Discharge (DC) Plans – Must be initiated upon admission

Discharge date *(tentative)* (MM/DD/YYYY)	Home evaluation date (MM/DD/YYYY)	Home/number of levels	Home/number of steps	Discharge
		☐ 1 ☐ 2 ☐ 3 ☐ Other	☐ Entry _____ ☐ Bed/bath _____	☐ Home alone ☐ HHC/Company ☐ Family/Support ☐ ALF ☐ LTC ☐ Other

DC barriers	
Equipment	
Supervision needs	

Section V: Authorized Signature

Name and Credentials of person completing form	Signature	Date (MM/DD/YYYY)
	x	

Section VI: Instructions. Complete this form and fax to number below.

NOTE: Please include hospital admission H&P, discharge summary (if available) and pertinent consultation notes, PT/OT plan, etc.

QualChoice Health Insurance | ATTN: Care Management | F: 501.228.9413

Internal Use Only

☐ MCG Met
☐ Policy Met
☐ Re-sending fax

☐ Precertification
☐ Recertification