BlueCross BlueShield Nebraska

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CLEAR FORM

Long-Term Acute Care Hospital (LTACH) Assessment Form

☐ **Please Expedite***

Justification for Expedited Request:

Submit requests to:

Fax: 866-422-5120

Phone: 877-399-1671

If no justification given, request will be processed as standard

*Please ONLY check this option if the provider believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy (CMS definition)

1. Member Information & Background

Patient Name: _____

Member/Patient ID Number:_____

Patient DOB:_____Pt. phone: _____

Patient Address: _____

_____

ICD10Code(s):_____

CPT Code(s):_____

Date of Admission: _____ ☐ TBD

Type: ☐ LTACH

Visits/Units/Days:_____

Authorization Date Span:_____-_____

Previous auth # (if applicable):_____

Requesting Provider: _____

Requesting Provider NPI#:_____

Treating Provider:_____

Treating Provider NPI#: _____

Admitting Provider: _____

Admitting Provider NPI#:_____

Servicing Facility:_____

Svc Facility NPI#: _____

Facility Reviewer Name: _____

Phone #: _____ Fax #: _____

Admitting diagnosis with summary of acute hospital admission:

Past Medical History:

Surgical/Procedures and Dates:

This form must be filled out completely. Chart notes are required and need to be submitted with this request. Incomplete requests will be returned to the requester.

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Member Name: _____
Member ID: _____

Today's Date:_____

☐ Initial Assessment

☐ Reassessment Last approved date: _____

Chart notes are required to be submitted with this request:
- **Hospital admission H&P**

As applicable also submit:
- **Pre-admission form**
- **Therapy (PT/OT/ST/wound)**
- **Care coordination notes to include social worker notes.**

2. Clinical Information

Height: _____ Weight: _____

BP: _____ HR: _____

Respiratory Rate: ____ Temperature: _____

Pulse ox:_____% NC / Liters: _____

A & O x: ☐ x1 ☐ x2 ☐ x3 ☐ x4

Neurologically Stable Last 24 hours? ☐ Y ☐ N

Continuous Sedation / Paralytics: ☐ Yes ☐ No

Telemetry: ☐ Yes Cardiac Rhythm: _____

NYHA Class III or IV: ☐ Yes ☐ No ☐ N/A

Diet: ☐ NPO ☐ Oral ☐ TF ☐ TPN

Rate/Frequency/Type: _____

Bladder: ☐ Incontinent ☐ Catheter _____

Bowel: ☐ Incontinent ☐ Ostomy _____

Dialysis: ☐ Yes ☐ Acute ☐ Chronic
☐ Hemodialysis ☐ Peritoneal Dialysis

Dialysis Access: _____ Freq/Days: _____

Tracheostomy: ☐ Yes Type:_____

Size: _____ Decannulation Trial: _____

Suction Freq:_____

Color & Amount:_____

Respiratory Tx: ☐ Yes _____

Vent: ☐ Yes PEEP: _____

FiO2: _____TV: _____ Rate: _____

Mode: _____

Vent Weaning Progression or Vent Wean Date:

_____

☐ CPAP ☐ BiPAP

How Long: _____

Oxygen Saturation Response: _____

CXR Stable / Improving? ☐ Yes ☐ No ☐ N/A

Pain Location: _____

Pain Treatment: _____

3. Labs

Hct:_____Hgb:_____Date:_____

Labs improved/unchanged last 24 hrs: ☐ Yes ☐ No

Blood Products: ☐ Yes ☐ No

Pertinent Labs and Cultures: _____

Blood Sugar Check Freq: _____ Range: _____

Coverage: _____

Isolation? ☐ Yes ☐ No Type: _____

Member Name: _____

Member ID: _____

4. Medications

IV medications, with ending dates:

Vascular Access/Central lines:

Significant medications that affect functioning:

5. Skin

Skin Intact? ☐ Yes ☐ No

Wound /Incision #1: Stage:_____

Location: _____

Wound Vac: ☐ Yes ☐ No

Size (L x W x D in cm)/Description: _____

_____

Treatment/Frequency: _____

Wound /Incision #2: Stage: _____

Location: _____

Wound Vac: ☐ Yes ☐ No

Size (L x W x D in cm)/Description: _____

_____

Treatment/Frequency: _____

For additional wounds use section 12

6. Prior Level of Function

Prior level of function ADLs: _____

Resides: ☐ Alone ☐ W/ Spouse ☐ Other _____

Support: ☐ Spouse ☐ Children ☐ Others _____

Home Description (steps to enter, levels, bed / bath location, etc.):

7. Key for Mobility and Self-Care Functioning

I	Independent
MI	Modified Independent
Sup	Supervision
SBA	Standby Assist
CGA	Contact Guard Assist

Min	Minimal
Mod	Moderate
Max	Maximum
Total	Total Assist

Member Name: _____
Member ID: _____

8. Physical Therapy

Bed Mobility: _____

Transfers: _____

Ambulation: _____

Distance: _____

Assistive Devices: _____

Stairs: _____

9. Occupational Therapy

Feeding: _____

Bathing (Upper Body): _____

Dressing (Upper Body): _____

Bathing (Lower Body): _____

Dressing (Lower Body): _____

Grooming: _____

Toileting / Hygiene: _____

ADL/Toilet Transfers: _____

10. Speech Therapy

☐ Dysphagia Evaluation

☐ Modified Barium Swallow

☐ Aspiration Risk

Results/Risks /Recommendations:

Member Name: _____

Member ID: _____

10. Discharge plans

D/C Date: _____ ☐ Tentative ☐ Actual

D/C Follow-up Appt Date: _____

D/C with: ☐ HHC Provider _____

☐ Outpatient Provider _____

☐ DME _____

Contact Person at D/C: _____

Barriers to Discharge:

Discharge To _____

Provider Name/Specialty: _____

HHC Phone: _____Fax _____

OP Prov. Ph#:_____ Fax:

DME Phone: _____ Fax:_____

Contact Phone # at D/C: _____

11. Additional Comments