BlueCross BlueShield of North Carolina MEDICARE

Long Term Acute Care (LTAC) Precertification Worksheet

Please note, this form applies to Healthy Blue + Medicare℠ (HMO POS D-SNP) offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC).

E-mail this form to: MedicareAdvantage@healthybluenc.com.

If you are not set up on secure e-mail, please email us your contact information and we will contact you to assist with setting up secure e-mail. You can also fax this form to:

- Initial: 844-211-7140
- Concurrent: 844-211-7141

Your request may be delayed if all requested information is not provided.

Please provide case reference number if for continued stayed review: _____

Date form completed:	
Date form sent to Blue Cross NC:	

Please place an X in the box to show what service is being requested:

LTAC medical (complex IV meds or wounds):		LTAC vent:	
Admit date to LTAC:			

Demographic Information	
Member name:	
DOB:	
Member ID#:	
LTAC facility name:	
LTAC NPI#:	
LTAC address, city, state, ZIP:	
LTAC contact name:	
LTAC contact phone/fax number:	
MD who will follow member at LTAC:	
MD NPI#:	
MD phone number:	
MD address, city, state, ZIP:	

https://www.bluecrossnc.com/providers/networks-programs/blue-medicare/healthy-blue-medicare

Blue Cross and Blue Shield of North Carolina Senior Health, DBA Blue Cross and Blue Shield of North Carolina, is an HMO POS D-SNP plan with a Medicare contract and a NC State Medicaid Agency Contract (SMAC). Enrollment in Blue Cross and Blue Shield of North Carolina Senior Health depends upon contract renewal.

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Transfer Information	
Transfer from:	
Admission date to short-term acute hospital:	
Name of contact at transferring facility: (prefer SW or CM):	
Phone/fax of contact at transferring facility:	
Diagnosis for LTAC admission (include ICD-10 code):	
Reason for LTAC admission:	

Past medical history (PMH) **Chronic conditions must be added here.**

Prior Level of Function (PLOF) **Note: This must be measurable.**	
Does member ambulate? (yes/no):	
If yes, how many feet?	
Level of assistance:	
Wheelchair mobility; self-propel (yes/no):	
Transfers:	
Activities of daily living (ADLs):	
Durable medical equipment (DME):	
Community resources already in place? (for example, Meals on Wheels, Waiver Program):	
Mental Status	
Baseline mental status:	
Current mental status/ability to follow commands:	
Home Set Up	
Number of steps to home:	
Rails (yes/no):	
Bed 1st floor (yes/no):	
Bath 1st floor (yes/no):	
Is there ability for 1st floor set up:	
Member lives with:	
Is caregiver available 24 hours a day: (yes/no):	
If yes, is caregiver able to assist at current level of function (yes/no):	
Potential family contact name and phone:	

Clinical Review Initial OR Concurrent		
Date:		
Estimated length of stay in LTAC level of care:		
Nursing/medical needs:		
Vitals:		
Abnormal labs/cultures:		
Radiology:		
Cardiovascular/telemetry status:		
IV medications (Must include medication, dose, frequency, route, stop date, and next MD appointment. No need to note routine meds):		
Respiratory (Is this patient on a vent, standard O2, or Highflow O2?):		
Vent status:	Date initiated:	
	Vent mode:	
	Tidal volume:	
	O2%:	
	Pressure support:	
	PEEP:	
	Misc:	
Vent weaning attempts x3? (most recent):	Date/why failed?:	
	Date/why failed?:	
	Date/why failed?:	
Trach:	Size:	
	Date placed:	
	Suctioning/ frequency:	
	Secretions amount/color:	
GI/GU oral diet (yes/no and define type):		
NG/peg tube:	Date placed:	
	Goal rate:	
	Current rate and formula:	
	Tolerating? (yes/no):	
TPN (Access, stop dates, rate, how tolerating, if they were on previously at home):		
Wounds and Treatment		
Wound #_____	Location:	
	Type/stage:	

	Measurement:	
	Tx/frequency:	
Wound #_____	Location:	
	Type/stage:	
	Measurement:	
	Tx/frequency:	
Wound #_____	Location:	
	Type/stage:	
	Measurement:	
	Tx/frequency:	
Physical and Occupational Therapy		
Date of therapy evaluation:		
Date of current therapy status:		
Weight bearing status:		
Ambulation:		
Wheelchair mobility (if applicable):		
Bed mobility:		
Transfers:		
Stairs:		
Balance:		
Feeding:		
Grooming/hygiene:		
Bathing:		
Dressing:		
Toileting:		
Speech therapy:		
Discharge Information		
Teaching/training on proper treatment (to include teaching that needs to be completed or that was successful and/or unsuccessful:		
Anticipated disposition:		
Barriers to discharge:		
Discharge plan:		
Estimated discharge date:		
Care conference date/discussion:		
Referred to home healthcare (HHC) (yes/no): If yes, name of company:		
DME needed: (If yes, what?)		
Community resources needed: (If yes, what?)		
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.