Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ Precertification ☐ Recertification

Complete this form and E-fax/email to:
urgentinpatientprecertrequests@bcbsm.com
Fax Number: 1-866-225-4905

Urgent Admission Fax Assessment Form 12/13/11

This request for precertification must be attested by the admitting physician indicating this is an urgent admission for a condition jeopardizing the member's life or health and is deemed life threatening.

Facility and provider must participate with local Blue Cross Blue Shield plan or member may incur sanctions.

Precert does not guarantee payment. Please verify eligibility and benefits prior to request.

Incomplete submissions will not be processed and will be returned to you

Physician Attestation	
I attest that this admission falls under the above mentioned criteria of an Urgent Admission:	
Physician signature:	**Date:**

Contact Information		
Contact name:	Title:	
Signature:	Date:	
Contact phone number:	Fax number:	e-mail:
Patient Information		
Name:	**DOB:**	**Contract #:**
Address:		

Admission Demographics			
Precertification			
☐ **Inpatient acute**	☐ **Skilled nursing**	☐ **Acute rehab**	☐ **Long-term acute care**
Admission date:		**Estimated length of stay:**	
Facility name:			
Facility address:			
Facility ID code /NPI #:		Facility phone:	
Admitting physician:			
Physician address:			
Physician ID code/Provider NPI #:		Physician phone:	

Surgical Admissions	
Surgery date:	
Surgical procedure and CPT codes: 1) 2)	

Recertification	
# Days requested:	Current estimated length of stay:
Last covered date:	

Medical Admissions
Admitting diagnosis and ICD9 codes: **1)** **2)** **Height:** _____ **Weight:** _____ **BP:** _____ **HR:** _____ **Respiratory Rate:** _____ **Temp:** _____

ER/ADM assessment and treatment:

Past medical history/Co-morbidities/Family history:

Pertinent labs/Imaging/Other test results:

Admission orders/Current treatment plan:

Current medications and frequency:

Skilled Nursing or Acute Rehab Admissions

What is the patient's current mobility function:

What is the patient's current self care function:

Pain Status

Pain: ☐ Yes ☐ No	**Location**:	**Rating**: (out of 10)

Pain meds and frequency taken:

Relief: ☐ Yes ☐ No **Rating:**

Case Management

BCBSM offers case management assistance for discharge planning. Would you like a referral made to our case management department? ☐ **Yes** ☐ **No**

Discharge Plans (needs to be initiated upon admission)

Discharge date (tentative/actual): **Discharge to home:** ☐ yes ☐ no **Assistive devices:**

Resides: ☐ Alone ☐ w/Spouse ☐ w/Other	**Support:** ☐ Spouse ☐ Children ☐ Family/Friends ☐ HHC ☐ Other

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

ALOC: ☐ Rehab ☐ SNF ☐ LTC ☐ Assisted Living ☐ Other