

☐ **Please Expedite***

Justification for Expedited Request:

If no justification given, request will be processed as standard

Skilled Nursing Facility and Inpatient Rehabilitation Assessment Form

Submit requests to:

Online: welcome.wellmark.com

Fax: 866-313-8595

Phone: 855-673-4225

*Please ONLY check this option if the provider believes 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: _____

Previous auth # (if applicable): _____

Member/Patient ID Number: _____

Requesting Provider: _____

Patient DOB: _____ Pt. phone: _____

Requesting Provider NPI#: _____

Patient Address: _____

Treating Provider: _____

ICD-10 Code(s): _____

Treating Provider NPI#: _____

CPT Code(s): _____

Admitting Provider: _____

Date of Admission: _____ ☐ TBD

Admitting Provider NPI#: _____

Type: ☐ Inpatient Rehab ☐ SNF

Servicing Facility: _____

Visits/Units/Days: _____

Svc Facility NPI#: _____

Authorization Date Span: _____ - _____

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.

This communication may contain confidential Protected Health Information. This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is STRICTLY PROHIBITED by Federal law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Member Name: _____

Member ID: _____

Today's Date: _____

☐ Initial Assessment

☐ Reassessment Last approved date: _____

Chart notes are required to be submitted with this request, including:

- **Hospital admission H&P**
- **Therapy notes (PT/OT/ST/wound)**
- **Care coordination notes to include social worker notes.**

For SNF members, fax a signed/dated NOMNC form prior to member discharge.

2. Clinical Information

Height: _____ Weight: _____

BP: _____ HR: _____

Respiratory Rate: _____ Temperature: _____

Pulse ox: _____% NC / Liters: _____

A & O x: ☐ x1 ☐ x2 ☐ x3 ☐ x4

☐ Tracheostomy ☐ CPAP ☐ BiPAP

Type: _____ Size: _____

Suction Freq: _____

Color & Amount: _____

Respiratory Tx: ☐ Yes ☐ No _____

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: _____

Pain Location: _____

Pain Treatment: _____

3. Medications

IV medications, with ending dates:

Vascular Access/Central lines:

Significant medications that affect functioning:

Member Name: _____

Member ID: _____

4. Skin

Skin Intact? ☐ Yes ☐ No

Wound /Incision #2: Stage: _____

Wound/Incision #1: Stage: _____

Location: _____

Location: _____

Wound Vac: ☐ Yes ☐ No

Wound Vac: ☐ Yes ☐ No

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

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

Treatment/Frequency: _____

Treatment/Frequency: _____

For additional wounds use section 11

5. 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.):

6. 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: _____

7. Physical Therapy

Bed Mobility: _____

Transfers: _____

Ambulation: _____

Distance: _____

Assistive Devices: _____

Stairs: _____

8. Occupational Therapy

Feeding: _____

Bathing (Upper Body): _____

Dressing (Upper Body): _____

Bathing (Lower Body): _____

Dressing (Lower Body): _____

Grooming: _____

Toileting / Hygiene: _____

ADL/Toilet Transfers: _____

9. Speech Therapy

☐ Dysphagia Evaluation

☐ Modified Barium Swallow

☐ Aspiration Risk

Results/Risks /Recommendations:

Member Name: _____

Member ID: _____

10. Discharge plans

D/C Date: _____ ☐ Tentative ☐ Actual

Discharge To _____

D/C Follow-up Appt Date: _____

Provider Name/Specialty: _____

D/C with: ☐ HHC Provider _____

HHC Phone: _____ Fax _____

☐ Outpatient Provider _____

OP Prov. Ph#: _____ Fax: _____

☐ DME _____

DME Phone: _____ Fax: _____

Contact Person at D/C: _____

Contact Phone # at D/C: _____

Barriers to Discharge:

11. Additional Comments