Medicare Post-Acute Facility Continued Stay Review Form

For PACE and FC Partnership Members ONLY

For Family Care (LTC) members call 1-866-937-2783, Option #3

Please complete this form and fax along with supporting clinical documentation to: Community Care Utilization Management Fax: 414-384-8272, phone: 262-207-9393, please call UM with any questions.

Incomplete forms or lack of supporting clinical may cause delay in determination or administrative denial for lack of clinical information.

Member Name:	DOB:	Medicare #: Medicaid #:
Provider Name/Clinic:		Tax ID:
Clinical Review:	Phone Number:	Fax Number:
Contact/Title:		
DATE OF REVIEW:		

Skilled Nursing Services: Frequency:_____ Detailed, current notes regarding the services: -Ventilator Settings and RT notes -Wound Care Notes (Dimension, Treatment Orders -IV Antibiotic Information (Dose, Frequency, Stop Date)	Update Enter Here:

Physical Therapy: Frequency:					
Transfers:	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
Ambulation:_____ (feet using device)_____	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
Gait (describe):			Balance (describe):		
Stairs: ☐Yes ☐NO_____ # of stairs					

Occupational Therapy: Frequency: _____					
ADL's Upper Body	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
ADL's Lower Body	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
Toileting:	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____
Bed Mobility:	☐Max A	☐Min A	☐CGA	☐Independent	☐Other_____

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Speech Therapy:	
Frequency:	Diet:
Progress:	

SNF Medicare A Discharge Plan:	
Projected SNF MED A discharge/LCD date:	Barriers to discharge:
Weekly Update/Progress towards established plan of care goals:	