GEISINGER HEALTH PLAN

Geisinger

SKILLED NURSING FACILITY PRE-CERT WORKSHEET

PLEASE FILL OUT COMPLETELY

Fax completed form (3 pages) to 570-953-0368ATTN: SNF Case Managers

PLEASE ***PRINT*** LEGIBLY – USE ONLY STANDARD ABBREVIATIONS WHERE NECESSARY			
Date of admission to SNF:		**SNF name:**	
Member name:		**SNF fax #:**	
GHP ID#:		**Requesting provider:**	
Member DOB:			

PRE-ADMISSION INFORMATION

Diagnosis:	**ICD#:**	
Additional current diagnoses:		

Pertinent PMH: ☐ CAD ☐ CHF ☐ COPD ☐ CVA ☐ DM ☐ DJD ☐ HTN ☐ PVD ☐ ESRD ☐ Dementia ☐ Other (please specify)

_____

_____

_____

Past surgical history: ☐ Amputation ☐ CABG ☐ Joint replacement ☐ Spinal ☐ Other _____

Prior level of function: _____

Patient lives: ☐ Alone ☐ With spouse ☐ PCH/ALF ☐ ICF ☐ Other _____

Home: Levels_____ Steps_____ Bedroom on _____floor Bathroom on _____ floor

Spouse/other able to care for member at home: ☐ Yes ☐ No If other, please identify _____

Services requested: ☐ PT ☐ OT ☐ ST ☐ RT ☐ Skilled nursing

Requestor's name (Please print legibly): _____

Requestor's phone number: _(____)_____ Requestor's fax number: _(____)_____

Requestor's signature: _____ Date:_____

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MEDICAL STATUS	***Member name:***
DATE FORM COMPLETED:	**REMARKS:**
Mental Status:	
Alert:	
Oriented:	
Follows commands:	
***Tube feedings*:**	
Peg: J. Tube: Date Placed:	
Bowel/bladder:	
Ostomy: Yes or No Type:	
Approx. Date of ostomy:	
Foley or straight cath:	
Weight (in pounds): ***Height:***	
Skin integrity:	
Intact:	
Wound care:	
Decubitus:	
Surgical:	
Respiratory:	
O2:	
Vent:	
C-PAP/BiPAP:	
Trach:	
Suctioning:	
Treatments:	
Medications:	
IV Med:	
Via: Frequency:	
Pain management:	
Specialty equipment needs:	
Medically stable/hemodynamically stable: Yes: ☐ No: ☐	
If yes, please explain below:	

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FUNCTIONAL STATUS	***Member name:***							
I = Independent	**Mod I = Modified Independent**	**SU= Set Up**	**SPV = Supervision**	**CG = Contact Guard**	**MIN = Min Assist**	**MOD = Mod Assist**	**MAX = Max Assist**	**D = Dependent**

WHAT DATE WAS THE FOLLOWING INFO PROVIDED BY THERAPY:	**REMARKS:**
Bed mobility:	
Supine – sit	
Transfer:	
Bed (sit – stand)	
Toilet TX	
Ambulation:	
Weight bearing status	
Distance (in feet)	
Assistive device	
Amount of assistance	
Stairs	
Balance:	
Standing	
Sitting	
ADL status:	
Self feeding	
Grooming	
Upper extremity dressing	
Lower extremity dressing	
Toileting	
Upper extremity bathing	
Lower extremity bathing	
Adaptive equipment	
Orthotic/prosthetic	
Speech Therapy	
Dysphagia	
Diet	
Communication	
Cognition	

*Required information. Incomplete forms will be returned unprocessed.
Precertification authorization verifies medical necessity criteria have been met and is not a guarantee of payment.