



## 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:
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Physical Therapy: Frequency: _____					
Transfers:	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other _____
Ambulation: _____ (feet using device) _____	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other _____
Gait (describe):			Balance (describe):		
Stairs: <input type="checkbox"/> Yes <input type="checkbox"/> NO _____ # of stairs					

Occupational Therapy: Frequency: _____					
ADL's Upper Body	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other _____
ADL's Lower Body	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other _____
Toileting:	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> Other _____
Bed Mobility:	<input type="checkbox"/> Max A	<input type="checkbox"/> Min A	<input type="checkbox"/> CGA	<input type="checkbox"/> Independent	<input type="checkbox"/> 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:	