MassHealth/Masspro
Telephone: **1-800-554-5127**
Fax: **1-800-752-6334**

Chronic/Rehab
Preadmission Screening

Requested Screening:

☐ **Admission** Submit pgs. 1, 2, & 6.
☐ **Concurrent** Submit pgs. 3 & 6.
☐ **Conversion** Submit pgs. 1, 4, & 6.
☐ **Rereview (Reconsideration)** Submit pg. 5.

Member (Patient) Information

Member ID:	Member name:
DOB:	Gender: ☐ M ☐ F
Address:	
Guardian:	
Guardian address:	

Requesting Provider Information

Provider ID/Service Location:	or NPI:
Specialty:	
Address:	
Contact name:	
Tel. no.:	Fax:
Name of physician contact for peer-to-peer discussion:	
Tel. no.:	Availability:

Admitting Facility Information

Provider ID/Service Location:	or NPI:
Name:	
Tel. no.:	Fax:
Address:	

Attending Physician Information (at the admitting facility)

Provider ID/Service Location:	or NPI:
Specialty:	
Attention (contact person for the attending):	
Name:	Tel. no.:
Address:	

Admission Screening

(Be sure to complete pages 1, 2, and 6.)

Assignment (admission type): ☐ Chronic ☐ Rehab

Requested admission date: _____ Requested length of stay (LOS): _____

Accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: ☐ MV-Driver ☐ MV-Passenger ☐ MV-Pedestrian ☐ Work ☐ Fall

☐ Other: _____

Out of state? ☐ Yes ☐ No If yes, reason: _____

Late submission? ☐ Yes ☐ No If yes, reason: _____

Hospital patient account number (if available): _____

	Diagnosis Code	Diagnosis Description
Primary Diagnosis		
Diagnosis 2		
Diagnosis 3		
Diagnosis 4		
Diagnosis 5		

	Service Code	Service Description	Service Date
Primary Service Code			
Service Code 2			
Service Code 3			
Service Code 4			
Service Code 5			

Clinical Information

Ventilator dependent? ☐ Yes ☐ No TBI? ☐ Yes ☐ No Tracheotomy? ☐ Yes ☐ No

Please describe any clinical indications for admission and/or procedures (e.g., signs, symptoms, or test results) that may assist us in our review. Include past medical history and treatment/course of care at the acute facility:

For REHAB, please include the following information:

Current medical status: _____

Plan of care/goals: _____

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Discharge plan: _____

Concurrent Screening

(Be sure to complete pages 3 and 6.)

Current PAS#: _____

Hospital name: _____

Member name: _____

Requested level of care (LOC): ☐ Chronic hospital level of care (HLOC) ☐ Rehab hospital level of care (HLOC)
☐ Chronic/Rehab administrative days (AD)

Requested from date: _____ Requested additional lengh of stay (LOS): _____

Late request? ☐ Yes ☐ No If yes, reason: _____

Physician contact for peer-to-peer discussion:

Name: _____ Tel. no.: _____

Availability: _____

Clinical Information

Ventilator dependent? ☐ Yes ☐ No TBI? ☐ Yes ☐ No Tracheotomy? ☐ Yes ☐ No

Discharge plan: _____

Barriers to discharge: _____

Weekly team meeting results: _____

Estimated discharge date: _____

Assistance with discharge planning requested from MassHealth: _____

_____

Please describe any additional clinical indications (e.g., signs, symptoms, or test results) and/or procedures (treatments, wound measurements and descriptions, etc.) for extending the stay that may assist us in our review:

For REHAB, please include information on the continued plan of care/goals for the following:

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Goals: _____

Conversion Review

(Be sure to complete pages 1, 4, and 6.)

Reason for conversion: _____

Admission date: _____ Date of conversion: _____ Requested length of stay (LOS): _____

Assignment/Requested level of care (LOC): ☐ Chronic hospital level of care (HLOC)

☐ Rehab hospital level of care (HLOC) ☐ Chronic/Rehab administrative days (AD)

Accident? ☐ Yes ☐ No Date of accident: _____

Type of accident: ☐ MV-Driver ☐ MV-Passenger ☐ MV-Pedestrian ☐ Work ☐ Fall

☐ Other: _____

Out of state? ☐ Yes ☐ No If yes, reason: _____

Late submission? ☐ Yes ☐ No If yes, reason: _____

Hospital patient account number (if available): _____

	Diagnosis Code	Diagnosis Description
Primary Diagnosis		
Diagnosis 2		
Diagnosis 3		
Diagnosis 4		
Diagnosis 5		

	Service Code	Service Description	Service Date
Primary Service Code			
Service Code 2			
Service Code 3			
Service Code 4			
Service Code 5			

Clinical Information

Ventilator dependent? ☐ Yes ☐ No TBI? ☐ Yes ☐ No Tracheotomy? ☐ Yes ☐ No

Please describe any clinical indications for admission and/or procedures (e.g., signs, symptoms, or test results) that may assist us in our review. Include past medical history and plan of care:

For REHAB, please include the following information:

PT and OT (Please complete page 6 and submit with this form.): _____

_____

Cognition/SLP: _____

Goals: _____

Discharge plan: _____

Current PAS#: _____

Hospital name: _____

Member name: _____

Requested level of care: ☐ Chronic ☐ Rehab ☐ Administrative days (AD)

Requested from date: _____

Requested additional length of stay (LOS): _____

Late request? ☐ Yes ☐ No If yes, reason: _____

Please identify and address all decisions in the Admission Determination Notice with which you disagree, and submit all additional information and documentation to support the medical necessity of the admission.

To facilitate physician-to-physician conversation:

I certify that I am the Requesting Provider/Attending Physician/Authorized Representative of the Admitting Facility (circle one) identified on this form. I certify that the information provided on this form and on any attachments, including medical necessity information (per 130 CMR 450.204) is true, accurate, and complete to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Name of physician the Masspro physician should contact: _____

Tel no.: _____

Availability: _____

PT and OT Information

Physical Therapy

	Current Status	Treatment Plan (also specify hours per day)	Goals
Assistive devices: (e.g., cane/crutches/walker/ rolling walker/wheelchair)			
Bed mobility			
Sitting/standing balance			
Transfers: • Bed to chair • Bathroom			
Ambulation–Distance			

Occupational Therapy

	Current Status	Treatment Plan (also specify hours per day)	Goals
Cognitive skills			
Activities of daily living			
Fine motor skills			
Gross motor skills			
Sensory processing			
Social skills			

Please include any additional information in the space below:

I certify that I am the Requesting Provider/Attending Physician/Authorized Representative of the Admitting Facility (circle one) identified on this form. I certify that the information provided on this form and on any attachments, including medical necessity information (per 130 CMR 450.204) is true, accurate, and complete to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.