Ohio Medicaid Managed Care/MyCare Ohio

Nursing Facility Request Form

Managed Care Entity Contact Information:

Instructions for Submitting Ohio Medicaid Managed Care/MyCare Ohio Nursing Facility (NF) Request Form

» Complete Sections I through VI of this form entirely and submit it to the appropriate managed care entity (MCE). A medical necessity and level of care determination will not be able to be completed if supporting documentation is not submitted with the form. To ensure a determination is able to be made by the MCE, the following documentation should be submitted with the form:
- ☐ Clinical documentation including diagnoses, medications, current therapy notes, wound descriptions, IV medication, ventilator dependency (if applicable), current assistive device(s) used, and validation of protective level of care (including the need for assistance with any instrumental activities of daily living).
- ☐ Documentation to support medical necessity using ODM criteria.
- ☐ Documentation to support that PASRR requirements have been met; the PASRR determination letter should be attached to this submission if available.
- ☐ Treatment plan or care plan; include a discharge plan if applicable and any noted barriers to discharge.
- ☐ Any other pertinent information or noted barriers to reach goals.

» A signed order from a physician, nurse practitioner, or physician's assistant may be included in the clinical documentation in lieu of providing a signed certification on this form. If a signed order is not included in the clinical documentation, the certification signature on this form is required by one of the authorities listed above. When an order is used in lieu of the certification, the order should include the level of care under which the member is certified for admission to the NF.

» If applicable, include documentation showing previous level of care determination (include date of last level of care determination) or prior level of function.

» Requests for continued stays should be submitted in sufficient time prior to the end of the previous authorization.

» Routine requests will be determined within 10 calendar days; expedited/urgent requests will be determined within 48 hours.

Section I – Member Information		
Date of Request (mm/dd/yyyy)	**MCE Type** ☐ Medicaid ☐ MyCare	**Request Type** ☐ Initial ☐ Concurrent
Member Name		
Date of Birth (mm/dd/yyyy)	**Member ID Number**	**Member Phone Number**
Service Is ☐ Routine ☐ Expedited/Urgent*	**Signature of Requesting Provider if Urgent/Expedited Request**	

*The Expedited/Urgent service request designation should only be used if the treatment is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine.

Section II – Requesting Provider Information	
Requesting Provider Name	**Requesting Provider NPI/Provider Tax ID Number**
Requesting Provider Contact Name	**Phone Number/Fax Number**

Section III – Servicing Provider/Facility Information ☐ Same as Requesting Provider		
Servicing Provider/Facility Name	**Provider NPI**	**Provider Tax ID Number**
Contact Name	**Phone Number/Fax Number**	**Provider Status** ☐ Contracted ☐ Non-Contracted

Section IV – Service Information		
Admission Date (mm/dd/yyyy)	**Discharge Date**** (mm/dd/yyyy)	**LOC Request Date** (mm/dd/yyyy)
PASRR Requirements Met For (select one): ☐ Hospital Exemption (30 days) ☐ Respite Stay (14 days) ☐ Emergency Stay (7 days) ☐ Unspecified Time Approval ☐ Specified Time Approval (_____ days)		

**If Discharge Date is unknown, length of stay will be based upon medical necessity.

☐ **Member Attestation –** I understand my healthcare options and choose to receive nursing facility services.	
Member or Authorized Representative Signature (optional)	**Date** (mm/dd/yyyy)

Member Name:	**Date**:

Section V – Level of Care Information

A. ACTIVITIES OF DAILY LIVING (ADLs)

	Independent	*Supervision*	*Assistance*	*Source**
1. Bathing	☐	☐	☐	
2. Dressing	☐	☐	☐	
3. Eating	☐	☐	☐	
4. Grooming				
a. Oral Hygiene	☐	☐	☐	
b. Hair Care	☐	☐	☐	
c. Nail Care	☐	☐	☐	
5. Toileting	☐	☐	☐	
6. Mobility				
a. Bed	☐	☐	☐	
b. Transfer	☐	☐	☐	
c. Locomotion	☐	☐	☐	

B. MEDICATION ADMINISTRATION

☐ Independent ☐ Supervision ☐ Assistance	**Source of Information**

C. COGNITIVE IMPAIRMENT

List activities for which 24-hour supervision is required to prevent harm due to cognitive impairment and explain:

D. SYSTEMS REVIEW

Check if condition is unstable, if no abnormalities are reported, or if medical complications are present.

	Unstable	*No abnormalities*	*Medical Complication*
Eyes, Ears, Mouth, and Throat	☐	☐	☐
Neurological	☐	☐	☐
Pulmonary	☐	☐	☐
Cardiovascular and Circulatory	☐	☐	☐
Musculoskeletal	☐	☐	☐
Gastrointestinal	☐	☐	☐
Genitourinary	☐	☐	☐
Skin	☐	☐	☐

Source of Information

*List all sources of information for each item as follows: P=Physician, MR=Medical Record, C=Client, CG=Caregiver, AR=Authorized Representative, AO= Assessor Observation

Section VI – Level of Care (LOC) Assessment Summary and Recommendation

Activities of Daily Living (list total by category) ☐ Independent: ☐ Supervision: ☐ Assistance:	**Unstable Medical Condition** ☐ Yes ☐ No
Medication Administration ☐ Independent ☐ Supervision ☐ Assistance	**Needs 24 hour Supervision due to Cognitive Impairment** ☐ Yes ☐ No
Skilled Nursing Service(s) - list type(s) and frequency	**Skilled Rehabilitation Service(s) -** list type(s) and frequency

LOC Recommendation – based on review of the authorization form, it is recommended that the level of care indicated is appropriate. ☐ Intermediate ☐ Skilled

CERTIFICATION: I certify that I have reviewed the information contained herein, and that the information is a true and accurate reflection of the individual's condition. I certify that the level of care recommended above is required.

Signature	**Date**