STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
January 21, 2016

To: Hospital Administrators

From: Susan J. Tucker, Executive Director
Office of Health Services

Note: Please ensure that appropriate staff members in your organization are informed of the contents of this memorandum.

Re: Interim changes to Medical Eligibility Review, DHMH 257 processing and Administrative Day requests

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Per the previous transmittal sent to providers on January 12, 2016, Telligen will be assuming responsibility for performing utilization review services formerly conducted by Delmarva Foundation for Medical Care. The Department is working diligently with both Delmarva and Telligen to implement a smooth transition. To bridge the transition between the two vendors, the Department will take over certain responsibilities listed in this memorandum.

Delmarva will accept and process all submissions of the documents referenced in this memorandum through close of business Friday, January 22, 2016.

Beginning Monday, January 25, 2016, fax all requests directly to the Department at: (410) 333-5213. Please note this is a temporary fax number.

The Department will process all Medical Eligibility Reviews (MERs) formerly submitted through iEXCHANGE. This includes the DHMH 3871 and DHMH 3871b (including additional documentation). Please do not resubmit requests previously submitted to Delmarva.

In addition to MERs, the Department will also complete certification for DHMH 257 forms (Long Term Care Activity Report) to begin payment for full MA coverage or otherwise require UCA approval. All other DHMH 257 request reasons should follow the current submission process.

Finally, the Department will also process Administrative Days requests for nursing facilities, chronic and special pediatric hospitals (DHMH 1288).

All submissions must be complete and include all necessary attachments and be accompanied by the Department's Fax Cover Sheet. The Department updated these forms to expedite the review process. **The Department will return all requests that include old or incomplete forms, lack necessary supporting documentation, or do not include the Fax Cover Sheet.**

All forms are attached to this memorandum.

We appreciate your patience during this transition. Any general questions regarding the transition may be directed to dhmh.maltcf@maryland.gov.

cc: Maryland Hospital Association

STATE OF MARYLAND

DHMH

Office of Health Services
Medical Care Programs

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

FAX COVER SHEET

SENDER NAME _____
SENDER ORGANIZATION _____
SENDER FAX # _____
SENDER E-MAIL _____
SENDER PHONE # _____
APPLICANT/RECIPIENT NAME _____
PAGES (including cover sheet) _____

TYPE OF REQUEST

☐ Medical Eligibility Review request for Nursing Facility services (DHMH 3871B; DHMH 4345 and other PASRR documentation if required; DHMH 3871B Addendum if desired)

☐ Medical Eligibility Review request for Medical Adult Day Care Waiver (DHMH 3871B from hospitals, nursing facilities and Medical Day Care Center redeterminations only)

☐ Medical Eligibility Review request for Chronic or Special Pediatric Hospital services (DHMH 3871 or DHMH 3871B/Vent Questionnaire)

☐ Certification (DHMH 257) processing for begin pay for full Medicaid or otherwise require UCA approval

☐ Administrative Days request for nursing facilities (DHMH 2129)

☐ Administrative Days request for chronic or special pediatric hospitals (DHMH 1288)

The Department will return all requests that include old or incomplete forms or do not include the Fax Cover Sheet.

201 W. Preston Street – Baltimore, Maryland 21201
Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.maryland.gov

DHMH 3871

Maryland Medical Assistance Program

Medical Eligibility Review Form PLEASE PRINT OR TYPE

Level of Care/Services Requested (application for rehab hospitals must be accompanied by a plan of care from admitting hospital) (Please check)

Application Date: _____

Financial Eligibility Date:_____

Social Security #:_____

Medical Assistance #:_____

☐ Chronic Hospital* ☐Model Waiver*

(If patient is on a ventilator, please use the DHMH 3871B with the Ventilator Questionnaire)

Part A: Patient Demographics

Patient's Last Name: _____ Patient's First Name: _____

Patients Date of Birth: _____ Sex: ____Adm. Date: _____

Permanent Address: _____

_____ Name of Last Provider (Hospital, Long Term Care Facility)

Present location of Patient: (if different from above) Institution: _____

_____ Admission Date: _____

_____ Discharge Date: _____

Patient's Representative Name: _____ Relationship to Patient: _____

Representative Phone #: _____ Representative Address: _____

Is language a barrier to communication ability? ___**YES** ___**NO** _____

****

Part B: Physician's Plan of Care (Must be completed by physicians or designee)

Please fill out accurately and completely

Physicians Name: _____ Telephone #: _____ Address: _____

Primary Diagnoses which relate to need for level of care: _____

Secondary/Surgical Diagnoses currently requiring M.D. and/or Nursing intervention which relates to level of care:

_____ Date: _____

_____ Date: _____

Other pertinent findings (ex. Signs and symptoms, complications, lab results, etc… _____

_____

_____

_____

Is patient free from infection TB? ____**YES** ____ **NO** Determined by: ___ Chest X-Ray ___PPD Date: _____

T _____ P _____ R _____ B/P _____ HT _____ WT _____

Have any of the above vital signs undergone a significant change? ___**YES** ___**NO** If Yes explain: _____

_____

Diet (Include supplements and tube feeding solution) _____

Patient's Name: _____

Medication which will be continued:

Medication	Dosage	Frequency	Route	If PRN, avg frequency

Treatment which will be continued: Description Frequency Duration if Temporary

____ Ventilator: _____

____ O_2 (as well as sats and frequency): _____

____ Monitor (apnea/bradycardia (A/B), other: _____

____ Suctioning: _____

____ Trach Care: _____

____ IV Line/fluids (indicate central or peripheral): _____

____ Tube Feeding (specify type of tube): _____

____ Colostomy/ileostomy care: _____

____ Catheter/continence device (specify type): _____

____ Frequent labs related to nutrition/needs (describe): _____

____ Decubitus (include size, location, stage, drainage, and signs of infection, also Tx regimen): _____

_____

____ Other (specify): _____

_____

Have any medications or treatments recently been implemented, discontinued, and/or otherwise changed? Explain:

_____

_____

Impairments/devices (check all that apply) ___Speech ___Sight ___Hearing ___Other (specify) _____

___Devices/Adaptive Equipment _____

Active Therapy	Plan	Frequency	Est. Duration	Goal
Physical Therapy				
Occupational Therapy				
Speech Therapy				
Respiratory				
Others				

Patient's Name: _____

Rehabilitation Potential: _____

Discharge Plan: _____

*If requesting a level of care for rehab hospital, please answer the following questions:

1. Preexisting condition related to current physical, behavioral and mental functions and deficits: _____

_____

2. Reason for out-of-state placement (if applicable): _____

Is patient comatose? ___**YES** ___**NO** if yes skip parts C through E and go directly to part F.

PLEASE NOTE: For other adults applicants, complete parts C and D, skip E. For applicants under age 21, skip parts C and D, complete E.

****

Part C: Functional Status (Use one of the following codes)

(If assistive device (e.g., Wheelchair, Walker) used, note functional ability while using device)

0. Little or no difficulty (completely independent or setup only is needed
1. Supervision/Verbal cuing
2. Limited physical assistance by caregiver
3. Extensive physical assistance by caregiver
4. Total dependence on others

___ Locomotion (if using adaptive/assistive device, Specify type): _____

___ Transfer bed/chair

___ Reposition/Bed mobility

___ Dressing

___ Bathing

___ Eating

Appetite (Check one): ___ Good ___ Fair ___ Poor

Other functional limitations (describe) _____

Incontinence management (Circle applicable choices in each category) (Note status with toileting program and/or continence device, if applicable)

Bladder	Bowel	
0	0	Complete control-or infrequent stress incontinence
1	1	Usually continent-accidents once a week or less
2	2	Occasionally incontinent- accidents 2+ weekly, but not daily
3	3	Frequently incontinent- accidents daily but some control present
4	4	Incontinent- Multiple daily accidents

****

Part D: Cognitive/Behavioral Status

1. Memory/orientation Y=Yes N=No

Yes	No	
___	___	Can recall after 5 minutes
___	___	Knows current season
___	___	Knows own name
___	___	Can recall long past events
___	___	Knows present location
___	___	Knows family/caretaker

2. Cognitive skills for daily life decision making and safety (Check one)

___ Independent decisions consistent and reasonable

___ Modified/some difficulty in new situations only

___ Moderately impaired/decisions requires cues/supervision

___ Severely impaired/rarely or never makes decisions

3. Communication	0- Always	1-Usually	2-Sometimes	3-Rarely
Ability to understand others	_____	_____	_____	____
Ability to make self understood	_____	_____	_____	____
Ability to follow simple commands	_____	_____	_____	____

Patient's Name _____

4. Behavior issues (enter one code from A and B in the appropriate column)

A. Frequency
1= Occasionally
2=Often, but not daily
3= Daily

B. Easily Altered
1= Yes
2= No

Description of Problem Behaviors	A	B

5. Most recent mini-mental score _____ Date: _____
Previous mini-mental score _____ Date: _____

****

Part E: Functional/Cognitive Status – Pediatric

	Age Appropriate	Functioning Level	Adaptive Equipment	
Cognition			Wheelchair	
Social Emotional			Splints/Braces	
Behavior			Side Lyer	
Communications			Walker	
Gross Motor Abilities			Adaptive Seating	
Fine Motor Abilities			Communication Devices	
Feeding			Other	
Toileting				
Self Care				

Part F: Physician's Certification for Level of Care

This patient is certified as in need of the following services (Check One):

☐Chronic Hospital ☐Model Waiver

Other information pertinent to need for Long Term Care: _____

Physician's Signature: _____ Date: _____

Other than physician completing form: _____

Signature Title Phone Date

****

This area is for Agent Determination Only. DO NOT write in this area.

Renewal

___ Medical Eligibility Established MD Advisor ___
___ Medical Eligibility Denied
Effective Date: _____
Type of Service: _____
Certificate Period: From: _____ To: _____
Agent Signature: _____
Date: _____

___Medical Eligibility Established MD Advisor___
___ Medical Eligibility Denied
Effective Date: _____
Type of Service: _____
Certificate Period: From: _____ To: _____
Agent Signature: _____
Date: _____

DHMH 1288

Report of Administrative Days

Department of Health and Mental Hygiene

Medical Care Programs

Medical Care Finance & Compliance Administration

Report of Administrative Days

1. Patient: _____ 2. Medical Assistance #: _____
3. Hospital: _____ 4. Admission Date: _____
5. Diagnosis: (Adm.) _____ (Disc.) _____
6. Date Eligible for Other Level of Care: _____ 7. Level of Care Requested: _____
8. Other reasons for Extended Stay: _____

CASE ID:

9. Completion of Referral:
   a. Date social worker became active in case: _____
   b. Date UCA notified by hospital of initiation of Discharge Planning: _____
      (Utilization Control Agent – Delmarva (UCA)
   c. Level of Care Received (1) Date: _____

   (2) Method (Check one) ☐ 256R ☐ 257 ☐ Phone Call

10. Placement Efforts (Use extra sheet if necessary.)

Date	Facility	Results

11. Discharge Date and Name of Facility to which Discharged: _____
12. Length of Stay: _____ 13. Total Administrative Days: _____
14. Review Coordinator Signature: _____ Date: _____

++++++++++++++++++++++++**For Utilization Control Agent (UCA) Use Only** ++++++++++++++++++++

Dates UCA Reviewed Continuation of Administrative Days: _____

Days Approved: _____ Days Denied: _____

UCA Signature: _____ Date: _____

Report of Administrative Days

10. Placement Efforts (Use extra sheet if necessary.)

Date	Facility	Results

11. Discharge Date and Name of Facility to which Discharged: _____

DHMH 3871B
Maryland Medical Assistance
Medical Eligibility Review Form

Part A – Service Requested (*indicates required field)

*1. Requested Eligibility Date_____ 2. Admission Date_____

*3. Check Service Type Below:

☐ Nursing Facility-please attach PASRR documentation if necessary (see Part F)

☐ Program of All-Inclusive Care for the Elderly (PACE) ☐ Brain Injury Waiver

☐ Chronic Hospital/Special Hospital vent dependent only (all other CH/SH use 3871) – please attach the Supplemental Ventilator Questionnaire

☐ Model Waiver vent dependent only (all other MW use 3871) – please attach the Supplemental Ventilator Questionnaire

☐ Medical Adult Day Care (new applicants currently placed in a hospital or nursing facility only)

*4. Check Type of Request

☐ Initial ☐ Conversion to MA ☐ Medicare ended ☐ MCO disenrollment

☐ Readmission – bed reservation expired (NF) ☐ Transfer new provider ☐ Update expired LOC ☐ Corrected Date

☐ Significant change from previously denied request ☐ Recertification (MW/PACE only)

☐ Advisory (please include payment)

*5. Contact Name_____ *Phone_____ *Fax_____

*E-Mail_____ *Organization/Facility_____

Part B – Demographics (* indicates required field)

*1. Client Name: Last _____First _____ MI ___ Sex: M F (circle)

*SS# _____- ____- _____ * MA # _____ *DOB _____

*2. Current Address (check one) ☐ Facility ☐ Home

*Address _____*City _____*State_____ *ZIP_____ *Phone_____

Nursing Facility name (if applicable) _____Provider #_____

If in acute hospital, name of hospital_____

*3. Next of Kin/ Representative

*Last name _____ *First Name _____ *MI _____

*Address _____ *City_____ *State____ *ZIP_____ *Phone_____

*4. Attending Physician

*Last name _____ *First Name _____ MI _____

Address _____ *City_____ *State_____ *ZIP_____ *Phone_____

Part C – Diagnoses

*Primary diagnosis related to the need for requested level of care	*ICD-10 Code	*Description
Other active diagnoses related to the need for requested level of care	Descriptions	

Applicant Name _____

Part D – Skilled Services:

Requires a physician's order. Requires the skills of technical or professional personnel such as a registered nurse, licensed practical nurse, respiratory therapist, physical therapist, and/or occupational therapist. The service must be inherently complex such that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel. Items listed under Rehabilitation and Extensive Services may overlap.

Table I. Extensive Services (serious/unstable medical condition and need for service)

Review Item	# Days Required
1. Tracheotomy Care: All or part of the day	
2. Suctioning: Not including routine oral-pharyngeal suctioning, at least once a day	
3. IV Therapy: Peripheral or central (not including self-administration)	
4. IM/SC Injections: At least once a day (not including self-administration)	
5. Pressure Ulcer Care: Stage 3 or 4 and one or more skin treatments (including pressure-relieving bed, nutrition or hydration intervention, application of dressing and/or medications)	
6. Wound Care: Surgical wounds or open lesions with one or more skin treatments per day (e.g., application of a dressing and/or medications daily)	
7. Tube Feedings: 51% or more of total calories or 500 cc or more per day fluid intake via tube	
8. Ventilator Care: Individual would be on a ventilator all or part of the day	
9. Complex respiratory services: Excluding aerosol therapy, spirometry, postural drainage or routine continuous O2 usage	
10. Parenteral Feeding or TPN: Necessary for providing main source of nutrition.	
11. Catheter Care: Not routine foley	
12. Ostomy Care: New	
13. Monitor Machine: For example, apnea or bradycardia	
14. Formal Teaching/Training Program: Teach client or caregiver how to manage the treatment regime or perform self care or treatment skills for recently diagnosed conditions (**must be ordered by a physician)**	

Table II. Rehabilitation (PT/OT/Speech Therapy services) Must be current ongoing treatment.

Review Item	# Days Required
15. Extensive Training for ADLs. (restoration, not maintenance), including walking, transferring, swallowing, eating, dressing and grooming.	
16. Amputation/Prosthesis Care Training: For new amputation.	
17. Communication Training: For new diagnosis affecting ability to communicate.	
18. Bowel and/or Bladder Retraining Program: Not including routine toileting schedule.	

Part E – Functional Assessment

Review Item	
FUNCTIONAL STATUS: Score as Follows **0 = Independent:** No assistance or oversight required **1 = Supervision:** Verbal cueing, oversight, encouragement **2 = Limited assistance:** Requires hands on physical assistance **3 = Extensive assistance:** Requires full performance (physical assistance and verbal cueing) by another for more than half of the activity. **4 = Total care:** Full activity done by another	**Score Each Item (0-4)**
1. Mobility: Purposeful mobility with or without assistive devices.	
2. Transferring: The act of getting in and out of bed, chair, or wheelchair. Also, transferring to and from toileting, tub and/or shower.	
3. Bathing (or showering): Running the water, washing and drying all parts of the body, including hair and face.	
4. Dressing: The act of laying out clothes, putting on and removing clothing, fastening of clothing and footwear, includes prostheses, orthotics, belts, pullovers.	

Applicant Name _____

5. Eating: The process of putting foods and fluids into the digestive system (including tube feeding).	
6. Toileting: Ability to care for body functions involving bowel and bladder activity, adjusting clothes, wiping, flushing of waste, use of bedpan or urinal, and management of any special devices (ostomy or catheter). This does not include transferring (See transferring item 16 above).	
CONTINENCE STATUS: Score as Follows **0 = Independent:** Totally continent, can request assistance in advance of need, accidents only once or twice a week or is able to completely care for ostomy. **1 = Dependent:** Totally incontinent, accidents three or more times a week, unable to request assistance in advance of need, continence maintained on toileting schedule, indwelling, suprapubic or Texas catheter in use or unable to care for own ostomy.	**Score Each Item (0-1)**
7. Bladder Continence: Ability to voluntarily control the release of urine from the bladder	
8. Bowel Continence: Ability to voluntarily control the discharge of stool from the bowel.	

Review Item	**Answer**	
Cognitive Status (Please answer Yes or No for EACH item.)	**Y**	**N**
9. Orientation to Person: Client is able to state his/her name.	☐	☐
10. Medication Management: Able to administer the correct medication in the correct dosage, at the correct frequency without the assistance or supervision of another person.	☐	☐
11. Telephone Utilization: Able to acquire telephone numbers, place calls, and receive calls without the assistance or supervision of another person.	☐	☐
12. Money Management: Can manage banking activity, bill paying, writing checks, handling cash transactions, and making change without the assistance or supervision of another person.	☐	☐
13. Housekeeping: Can perform the minimum of washing dishes, making bed, dusting, and laundry, straightening up without the assistance or supervision of another person.	☐	☐

14. Brief Interview for Mental Status (BIMS): Was the examiner able to administer the complete interview? If yes, indicate the final score. If no, indicate reason. (Examination should be administered in a language in which the client is fluent.)	☐ Yes Score_____ ☐ No Check one of the following: ☐ Hearing Loss ☐ Applicant is rarely/never understood ☐ Language Barrier ☐ Refused ☐ Other (specify)_____

Behavior (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
15. Wanders (several times a day): Moves with no rational purpose or orientation, seemingly oblivious to needs or safety.	☐	☐
16. Hallucinations or Delusions (at least weekly): Seeing or hearing nonexistent objects or people, or a persistent false psychotic belief regarding the self, people, or objects outside of self.	☐	☐
17. Aggressive/abusive behavior (several times a week): Physical and verbal attacks on others including but not limited to threatening others, hitting, shoving , scratching, punching, pushing, biting, pulling hair or destroying property.	☐	☐
18. Disruptive/socially inappropriate behavior (several times a week): Interferes with activities of others or own activities through behaviors including but not limited to making disruptive sounds, self-abusive acts, inappropriate sexual behavior, disrobing in public, smearing/throwing food/feces, hoarding, rummaging through other's belongings, constantly demanding attention, urinating in inappropriate places.	☐	☐
19. Self-injurious behavior (several times a month): Repeated behaviors that cause injury to self, biting, scratching, picking behaviors, putting inappropriate object into any body cavity, (including ear, mouth, or nose), head slapping or banging.	☐	☐

Communication (Please answer Yes or No for EACH item.)	**Answer**	
	Y	**N**
20. Hearing Impaired even with use of hearing aid: Difficulty hearing when not in quiet setting, understands conversations only when face to face (lip-reading), can hear only very loud voice or totally deaf.	☐	☐
21. Vision Impaired even with correction: Difficulty with focus at close range, field of vision is severely limited (tunnel vision or central vision loss), only sees light, motion, colors or shapes, or is totally blind.	☐	☐
22. Self Expression: Unable to express information and make self understood using any means (with the exception of language barrier).	☐	☐

23. Please provide any additional information that you believe supports that the client's health care needs cannot be safely met outside a nursing facility or in the absence of MADC, PACE, or Waiver services (use an addition sheet if necessary). You are strongly encouraged to use the 3871B Addendum and/or attach medical records for this purpose.

Part F – For Nursing Facility Applicants Only - ID/RC/MI Please Complete the Following

Review Item - If any of the below questions are answered Yes, please complete and attach the full Level I screen (DHMH 4345). If the Level I screen indicates that a Level II evaluation is necessary, please attach either the Categorical Advance Group Determination Form or certification that the person has been approved for admission under PASRR.	**Answer** Y	N
1. Is there a diagnosis or presenting evidence of intellectual disability/related condition (ID/RC), or has the client received services related to intellectual disability/related condition within the past two years?	☐	☐
2. Is there any presenting evidence of mental illness (MI)?	☐	☐
a. If yes, check all that apply. ___ Schizophrenia ___ Personality disorder ___ Somatoform disorder ___ Panic or severe anxiety disorder ___ Mood disorder ___ Paranoia ___ Other psychotic or mental disorder leading to chronic disability		
3. Has the client received inpatient services for mental illness within the past two years?	☐	☐
4. Is the client on any medication for the treatment of a major mental illness or psychiatric diagnosis? a. If yes, is the mental illness or psychiatric diagnosis controlled with medication?	☐ ☐	☐ ☐
5. Is the client a danger to self or others?	☐	☐

Part G – Certification

1. Signature of Person Completing Form: _____ Date_____

Printed Name_____ Title_____

I certify to the best of my knowledge the information on the form is correct.

Signature of Health Care Professional: _____Date_____

Printed Name_____ Title_____

UCA/DHMH Use Only ☐ Approved ☐ Denied Date of Decision_____

Certification Period _____

Signature_____ Date Signed_____

Print Name_____ Title_____

DHMH 3871B Addendum

Maryland Medical Assistance
Medical Eligibility Review Form
(Optional)

Last Name_____ First Name_____ MI___MA#_____ SSN/DOB _____

Contact Person_____ Phone_____ Fax_____

Secondary/Surgical diagnoses requiring physician and/or nursing intervention that support the client's need for care in a nursing facility, MADC, Waiver, or PACE_____

_____

Other pertinent findings (e.g., signs/symptoms, complications, lab results, etc.)_____

_____

Has the client been hospitalized in the past three months? ☐ Yes (please provide detail below) ☐ No

Date	Name of Hospital	# Days	Reason/Comments

Diet (include supplements)_____

Height_____ Weight_____ Blood Pressure_____ Have any of the above changed recently? ☐ Yes ☐ No

If yes, please explain_____

_____

Please list all medications that the client currently takes.

Medication	Dosage	Frequency	PRN?	Route	Reason	If PRN, how often given in the past **?

Are any of the above medications new, being frequently adjusted, or are there other problems with them? ☐ Yes (please explain) ☐ No

_____

_____

Please provide any addition information as to why you believe the person's health care needs cannot be safely managed outside a nursing facility, or in the absence of medical adult day care, Waiver, or PACE_____

_____

I certify to the best of my knowledge that the information on this form is correct.

Name of Physician or Nurse (please print or type)_____Signature_____ Date_____

LONG TERM CARE ACTIVITY REPORT (DHMH 257)

□ Community MA □ Waiver

TO: Receiving Agency____________________________________
Address ____
____

FROM: Name of Provider _____________________________________
Address____
____

For Agency Use Only
Date Received
Control No.
Due Date
Completed

Medicaid Provider ID______________________ CARES Vendor ID_______________________

Contact Name_______________________________ Telephone________________________

PROVIDER TYPE □ Nursing Facility □ Chronic/Special Hospital □ Medical Day Care Center □ Other_________________

RECIPIENT INFORMATION

Name ____ Sex □ M □ F Date of Birth ______________

Medicare Claim No. __________________________ MD Medicaid No. _______________________________________

Representative____ Phone______________________________

Address____

ACTION REQUESTED - COMPLETE EITHER BOX A OR B AS APPROPRIATE, AND PRINT AND SIGN NAME/DATE

* *

A. Begin Payment Admission Date____________ Private pay rate__________

Check all that apply - both beginning and ending pay dates must be completed when requested. NOTE: Actions marked with "*" require Utilization Control Agent/DHMH certification

1. □ *Full MA coverage Begin pay date______________ For MDC only □ Initial □ Continued
2. □ Medicare A co-payment Begin pay date __________ End pay date ____________
3. □ Bed reservations for Medicare full coverage period Begin pay date____________ End pay date_____________
4. □ *Revocation of Hospice care and return to NF care Effective date____________

* *

B. Cancel Payment

1. □ Discharged to □ Another Provider □ Community □ Hospice Date of Discharge _______________

   If discharged to another provider, name of provider ____

2. □ Death – Date of Death ____________________

* *

Administrator/Designee Signature____ Date______________________

Print Name of Administrator/Designee__________________________________ Title__________________________

Level of Care Certification (For UCA/DHMH Use Only)

The above named recipient is certified for the following level of care (check one):

□ Chronic/Special Hospital □ Nursing Facility Effective Dates _______________ through________________

_________________________________ _______________________________________ ____________________

Utilization Control Agent/DHMH Authorized Signature M/D/YYYY

DHMH 257 (Revised 4/2011)

AGENCY/UCA/PROVIDER COPY