

Contact Form

Referring Agency Use Only

Name of Contact: _____ Date of Contact: _____
Name: _____ Medicaid ID: _____
SS#: _____ Date of Birth: _____
Is client in a Medicaid HMO? Yes No
Does the client have any additional Insurance? Yes No
If yes, Name of Company _____ *(include a copy of front and back of card)*
Hospital: _____ Contact Person: _____
Provider #: _____ Phone Number: _____
Diagnosis and Current Treatment(s): _____

Nursing Facility *(referred to)*: _____ NF Contact Person: _____
Phone Number: _____ Anticipated Transfer Date: _____

DDM Utilization Reviewer Use Only

Qualifying Condition: Vent (Level I Level II Level III) Medically Complex Wound
ULTC 100.2 Completed Yes No Medicaid Pending or Eligible: Yes No
PASRR Approved? Yes No PASRR Level II Needed? Yes No
CSR On-site Review Date _____
Comments _____

Reviewed By: _____ Review Date: _____

HCPF Use Only

Hospital Rate Notification Date: _____ Nursing Facility Rate Notification Date: _____
Date payment to NF begins: _____ Initial per diem rate: \$ _____
Notes/Comments: _____

Rate Approved By: _____ Rate: _____

FAX TO DDM: Attention Pam Guess

(877)-431-9568