Member transfer coordination of care

Source plan: Receiving Plan:

End Date: Effective Date:

Member name: Medicaid ID#:

Address:

Phone: DOB:

MAID: Parent/Guardian:

Admissions/Rehabs

Is member currently an inpatient? Date of admission: Hospital name:

Has member been authorized for future admissions or ambulatory surgeries? Transplant:

Reason for admission other than transplant: Projected admission date:

Facility name: Number of pre-approved days:

Number of admissions in last quarter:

Date of last two admissions: Name of hospital(s):

Date of last two rehab admissions: Name of rehab(s):

Does member have behavioral health or history of substance abuse conditions?

If yes, then who is providing services for these conditions: (name and phone number)

Is the member currently inpatient for behavioral health/substance abuse treatment?

If yes, who is the servicing provider?

Is the member currently receiving outpatient behavioral health/substance abuse treatment?

Is this person receiving care under the Promise program?

Ongoing outpatient services

Will member be receiving any homecare, private duty nursing, home health aide, therapy or other outpatient services at time of transfer? (List all)

_____

_____

_____

_____

For each, identify CPT and ICD-9 code, start and end date, referring provider, agency supplying service and number of open service units.

List of open authorizations for outpatient diagnostic services (radiology, lab, etc.), including CPT and ICD-9 codes, referring and servicing provider, start and end date and number of open units.

_____

_____

_____

_____

Durable medical equipment (DME)/supplies

Please list any DME/supplies that member may have or has had while under your plan: for each, identify the CPT/HCPCS and ICD-9 codes, referring and servicing provider, whether rented, purchased, or rent to purchase. For rent to purchase items, identify status toward reaching purchase price and agencies providing each DME item.

_____

_____

_____

_____

Minor Home Modifications

Please list any Minor Home Modifications that member may have or has had under your plan: for each identify the date completed, servicing provider and cost per home modification project.

_____

_____

_____

Special needs/case management

Was member known to Special Needs Unit?

Is the member currently in the LTSS program?

If LTSS, date of last Level of Care Redetermination: _____

Is the member currently at Exceptional Care for Children or an out of state

Pediatric facility?

Is there a referral for a community resources/waiver/program in process/ pending?

Date of referral: _____ Name of agency/program/waiver: _____

Is member receiving case management services?

Is the member receiving Lifespan Waiver services?

Restrictions

Is member currently restricted to a pharmacy? Pharmacy name:

Pharmacy

Is member receiving narcotics? Narcotic Rx name:

Quantity of Rx: Date of last Rx:

List all open authorizations for IM injectables and infusions including medication name, dose, and end date for current authorization and for infusions location where infusions are to occur.

_____

_____

_____

_____

Appeals, grievances

Is the member actively seeking an appeal for services currently?

Does the member have any outstanding grievances currently?

Comments:

Note:

Completed by: