PATIENT INFORMATION

Medicaid ID:_____ **Provider Name**_____

Recipient Name:_____ **SSN:**_____ **DOB:**_____

Address:_____

I. Provider Section

Patient Status: (Complete Appropriate Blocks)

Patient admitted to this facility/service on _____(date)

Patient discharged or expired on _____ (date)

Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired

☐ Case in need of review/DMAS 122 requested

☐ Personal Funds Account balance $_____ as of _____ (date).

☐ Patient's income or deductions have changed: _____

Medicaid Per Diem Rate: $_____

☐ Explain/other:_____

Prepared by Name:_____ **Title:**_____

Telephone:_____ **Fax Number:** _____ **Date:**_____

II. DSS Section

Eligibility Information: (Complete Appropriate Blocks)

☐ Is eligible for full Medicaid services beginning _____(date)

☐ Is eligible for QMB Medicaid only ☐ Is eligible for Medicare premium payment only

☐ Is ineligible for Medicaid services

☐ * Is ineligible for Medicaid payment of LTC services from _____ to_____.

☐ Has Medicare Part A insurance ☐ Has other health insurance ☐ Has LTC insurance

III. Patient Pay Information

	MMYY	MMYY	MMYY
Effective Date	_____	_____	_____
Patient Pay Amount	$_____	$_____	$_____

*See Instructions for distribution on this form.

NOTE: Medicaid long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g., the SSA check received in January is used toward the cost of care in January.

Eligibility Worker Name:_____

Agency Name:_____ **FIPS Code:**_____

Telephone:_____ **Fax Number:** _____ **Date:**_____