Michigan Department of Health and Human Services

COMPLEX CARE PRIOR APPROVAL – REQUEST/AUTHORIZATION FOR NURSING FACILITIES

PRIOR AUTHORIZATION NUMBER

Fax: MDHHS Program Review Division (517) 241-7813

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

SECTION I:

Provider's Name	NPI Number		Phone Number
Provider's Address (Number, Street, Ste., City, State, Zip)			Fax Number
Beneficiary's Name (Last, First, Middle Initial)	Sex ☐ M ☐ F	Birth Date	mihealth Card Number

SECTION II: CARE STAFFING AND SUPPLIES

List the average number of nursing hours and supplies, vent, etc. required for this beneficiary's care that EXCEED the standard level of care and the corresponding rate of pay. *Attach additional information if necessary.*

Excess Nursing Hours	Charges Per Hour/Day	Total
RN _____ Hours Per Day	$ _____ Per hour	$ _____
LPN _____ Hours Per Day	$ _____ Per hour	$ _____
Aide _____ Hours Per Day	$ _____ Per hour	$ _____
Excess Daily Supplies		
Medical Supplies (e.g., vent)		
1.	$ _____ Per day	$ _____
2.	$ _____ Per day	$ _____
3.	$ _____ Per day	$ _____
4.	$ _____ Per day	$ _____
TOTAL		$ _____

SECTION III: ADDITIONAL COMMENTS

(250-Character Limit)

SECTION IV: PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

_____ _____

Provider Signature Date

MDHHS USE ONLY

Review action:
APPROVED ☐ INSUFFICIENT DATA ☐
DENIED ☐ NO ACTION ☐
APPROVED AS AMENDED ☐

Consultant remarks

Start Date	End Date	Units – Number of Days	Total Daily Rate
			$

_____ _____

Consultant Signature Date

Authority: Title XIX of the Social Security Act
Completion: Completion is required for Medicaid reimbursement.