Reset Form

Ohio Department of Medicaid

NURSING FACILITY PAYMENT AND ADJUSTMENT AUTHORIZATION

1. Medicaid Billing Number *(12 digits)*	12. DATE MEDICAID VENDOR PAYMENT TO START	MONTH	DAY	YEAR

2. Patient/Resident Name *(Last, First, MI.)*	13. Transferred From Another Facility, Enter Medicaid Provider Number *(7 digits)*
	___ ___ ___ ___ ___ ___ ___

3. National Providers Identifier (NPI)	14. Medicaid Vendor Payment End Date *Check One and Indicate Date* *(Medicaid Does NOT Reimburse for Day of Death)*		
4. Level of Care Effective Date	☐ Date Transferred to Another ___ ___ / ___ ___ / ___ ___	☐ Date Returned to Community ___ ___ / ___ ___ / ___ ___	☐ Date Deceased ___ ___ / ___ ___ / ___ ___
FACILITY INFORMATION	Transferred To Facility *Medicaid Provider Number (7 digits)* ___ ___ ___ ___ ___ ___ ___	☐ Date Medicare Began to Pay ___ ___ / ___ ___ / ___ ___	☐ Other (Explain Below) ___ ___ / ___ ___ / ___ ___
5. Medicaid Provider Number	16. Patient Liability		

6. Facility Name	17. Submitted For Payment Cycle	___ ___	0 1	___ ___

7. Address *(Street, City, Zip)*	**Adjustments**	**Begin Date A**	**End Date B**	**Totals C**	**Adjustment Code D**
	17. Days				
	18. Patient Liability			$	
8. County	19. Patient Liability			$	
9. Facility Type ☐ ICF/MR	20. Leave Days				
				Total Days Used To Date	
10. Contact Person	21. Co-Insurance			$	
11. Telephone Number ( )	22. Deductible			$	
	23. Other				

24. Explanation:	25. ☐ State Hearing Decision Date of State Hearing ___ ___ / ___ ___ / ___ ___

This is to certify that the foregoing information is true , accurate, and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

Provider Signature	Date

SEND TO: Long Term Care Payment Unit, Claims Reconciliation Section, P.O. BOX 182379, Columbus Ohio 43218-2379