

Ohio Department of Medicaid
FACILITY CDJFS TRANSMITTAL

Patient Information

Patient Name (<i>Last, First, MI</i>)		CRISE Case No.		
Medicaid Billing Number (<i>12 digits</i>)		Medicare Number		
Authorized Representative or Contact Person		Relationship to Patient		
Address	City	State	Zip	Telephone

Medical Benefits (Please attach a copy of both sides of benefits card [e.g., insurance, Worker's Compensation, Military, etc.]

Name		Address		
Policy Number	City	State	Zip	Telephone

Admission Information

Discharge Information

Admission Date _____ Admitted From <input type="checkbox"/> Home <input type="checkbox"/> NF <input type="checkbox"/> Hosp <input type="checkbox"/> RSS <input type="checkbox"/> Other <table style="width: 100%;"> <tr> <td style="text-align: center;">Begin Date</td> <td style="text-align: center;">End Date</td> </tr> <tr> <td><input type="checkbox"/> Managed Care _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Medicaid _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Medicare _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Private Pay _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Commercial Insurance _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Short Term Stay _____</td> <td>_____</td> </tr> </table>	Begin Date	End Date	<input type="checkbox"/> Managed Care _____	_____	<input type="checkbox"/> Medicaid _____	_____	<input type="checkbox"/> Medicare _____	_____	<input type="checkbox"/> Private Pay _____	_____	<input type="checkbox"/> Commercial Insurance _____	_____	<input type="checkbox"/> Short Term Stay _____	_____	Discharge Date _____ Type of Discharge <input type="checkbox"/> Transfer to NF <input type="checkbox"/> Death Date _____ <input type="checkbox"/> Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Hospice <input type="checkbox"/> Other <input type="checkbox"/> Hospital (Leave Days Exhausted)
Begin Date	End Date														
<input type="checkbox"/> Managed Care _____	_____														
<input type="checkbox"/> Medicaid _____	_____														
<input type="checkbox"/> Medicare _____	_____														
<input type="checkbox"/> Private Pay _____	_____														
<input type="checkbox"/> Commercial Insurance _____	_____														
<input type="checkbox"/> Short Term Stay _____	_____														

Name of Facility Patient Admitted to			Name of Facility Patient Discharged to		
Address			Address		
City	State	Zip	City	State	Zip
Medicaid Provider Number (<i>7-9 Digits</i>)	Area Code and Telephone Number		Medicaid Provider Number (<i>7-9 Digits</i>)	Area Code and Telephone Number	

NPI Number (10 digits) _____

Amount \$ _____ Effective Date of Change _____

Patient Income Information:
Change of Income (Attach Verification) *Check One* Increase Decrease

Type of Lump Sum (e.g. Social Security, Railroad Retirement, Sale of Property, Insurance Payment) _____ Date Received _____

Patient's Personal Needs Account (PNA) \$ _____ as of Effective Date _____ (to be completed when appropriate-see instructions)

Facility Authorized Signature _____ Date _____

County Information

County Name	County Number
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Medicaid (check all that apply) Approved Change Denied Closed Room and Board Payment Restricted Coverage Managed Care

Begin Date _____ End Date _____

Begin Date _____ End Date _____

Patient Liability \$ _____ Begin Date _____ End Date _____ Patient Liability \$ _____ Begin Date _____ End Date _____ Patient Liability \$ _____ Begin Date _____ End Date _____	Level of Care has been completed <input type="checkbox"/> Yes <input type="checkbox"/> No
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Type of Lump Sum: _____ Lump Sum \$ _____ Patient Liability \$ _____ Service Date Span _____ to _____

Qualified Medicare Beneficiary (QMB) Eligible? No Yes Effective Date _____

State Hearing Date of State of Hearing _____ Appeal Number _____

Comments _____

IM Worker Signature	Telephone Number	Date
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Distribution: - Original to: Return to facility upon completion; Copy to: County Department of Job and Family Services, Nursing Home Section; Copy Retained by Facility.