

Ohio Department of Medicaid
INSTRUCTIONS FOR COMPLETING ODM 09401, FACILITY/CDJFS TRANSMITTAL

GENERAL INSTRUCTIONS:

The ODM 09401 is the reporting document from the facility to the County Department of Job and Family Services (CDJFS) and from the CDJFS to the Long Term Care Facility (LTCF). The facility must report all admissions, changes, etc. via the ODM 09401 **with two exceptions:**

1. Leave days are reported on the 8371 for NF EDI claims and MRDD facilities would report non-covered leave days on the ODM 09400.
2. Adjustments to the Medicare crossover claims are reported on the 8371 EDI claim.

All entries should be typed or printed with the exception of signatures. Use MM/DD/YY format.

PATIENT INFORMATION:

All entries in this section are to be completed by the agency initiating the ODM 09401.

Patient Name: Enter the patient's name in the last name, first name, middle initial format.

CRIS-E Case Number: Enter the 10 digit CRIS-E case number.

Medicaid Billing Number (12 digits): Enter the 12 digit billing number from the patient's medical card.

Medicare Claim Number: Enter the patient's Medicare Claim Number.

Authorized Representative or Contact Person: Enter the full name of the patient's authorized representative or contact person if there is no authorized representative.

Relationship to Patient: Enter the relationship of the authorized representative or contact person for the patient.

Address/City/State/Zip: Enter the full address of the authorized representative or contact person for the patient.

MEDICAL BENEFITS:

This section must be completed if the patient has any medical insurance or benefits from sources other than Medicare or Medicaid. Attach a copy of both sides of the medical benefits card.

Name: Enter the name of the medical benefits company/agency.

Address/City/State/Zip: Enter the full address of the medical benefits company/agency.

Policy Number: Enter the policy number of the patient or policy holder.

Telephone Number: Enter the telephone number of the medical benefits company/agency.

ADMISSION INFORMATION:

Admission Date: Enter the date of the patient's admission to the facility. Use MM/DD/YYYY format.

Admitted From: Check the box that indicates the place from which the patient was admitted (e.g., home, LTCF etc.).

Type of admission: Check type of admission (e.g., Managed Care, Medicaid, Private Pay) and the appropriate begin and end dates next to the type.

DISCHARGE INFORMATION:

Discharge Date: Enter the date of the patient's discharge from your facility. Use MM/DD/YYYY format.

Type of Discharge: Check type of discharge (e.g., transfer to LTCF, home, etc.) If "Death" is checked, enter the date of death. If "Other" is checked, give a brief explanation in the comments field at the bottom of the ODM 09401 form.

FACILITY INFORMATION

Name of Facility Patient Admitted to or discharge from: Enter the full name of your facility.

Address/City/State/Zip: Enter the full address of your facility.

Medicaid Provider Number: Enter the 7-9 digit Medicaid provider number assigned to your facility.

Telephone Number: Enter the telephone number of your facility.

National Provider Identifier (NPI): Enter the NPI number assigned to your facility from Center for Medicare and Medicaid Services (CMS) National Plan provider numerical NPPAC

PATIENT INCOME INFORMATION:

Change of Income (Attach Verification): If the patient has a change in income, check increase or decrease and attach verification of the new income amount.

Amount: Enter the dollar amount of the change in income and the effective date of the change.

Type of Lump Sum Payment (e.g. Social Security, Railroad Retirement): Enter the type of lump sum payment received and the date received. Attach verification of the lump sum to the ODM 09401. **Patient's Personal Needs Account Balance (PNA):** If there is a change in the patient's personal needs account (PNA), complete the amount and the date of the change. Report changes to the PNA when it is within \$200.00 of the Medicaid resource limit.

FACILITY AUTHORIZED SIGNATURE/DATE: The person authorized to complete the ODM 09401 form must sign and date the form.

COUNTY INFORMATION:

County Name: Enter the county name.

County Number: Enter the 2 digit county number.

Medicaid (check all that apply): Check the appropriate box(s).

Begin and End Date(s): Enter the begin and/or end dates for box(s) checked.

Patient Liability: Enter all appropriate patient liability amounts with the begin and/or end dates.

Type of Lump Sum: Indicate the type of lump sum received. Enter the amount of the lump sum separate from the amount of patient liability. Enter the service date(s) to which these amounts apply. Do not add the two amounts.

Level of Care Has Been Completed: If level of care (LOC) has been completed and entered in CRIS-E, check the "yes" box and attach a screen print of the LOC to the ODM 09401 being returned to the facility. If there is not a completed CRIS-E in AEILC check the "no" box and advise the provider in the comment section that a LOC need to be completed. ***NOTE: The LOC must be appropriate for payment authorization to the LTCF.**

Qualified Medicare Beneficiary (QMB) Eligible: Indicate QMB eligibility by checking yes or no. If patient is QMB eligible, complete the effective date.

State Hearing: Check the box if the change indicated is the result of a state hearing. Enter the decision date and appeal number of the state hearing.

Comments: Complete if anything on the ODM 09401 needs further explanation or if "Other" was checked in the Facility Information Section.

CDJFS Caseworker Signature, Telephone Number, and Date: The CDJFS Caseworker must sign, date, and enter their telephone number.

Distribution: If the CDJFS completes the ODM 09401 a copy must be sent/returned to the LTCF.

If the LTCF completes the ODM 09401 a copy must be sent/returned to the CDJFS.

A copy to Medicaid upon request from the LTCF.

***NOTE: The LTCF and the CDJFS must retain a copy of the ODM 09401 in the patient's file/record.**