

**WISCONSIN MEDICAID
REQUEST FOR NURSING HOME CARE DETERMINATION**

Instructions: Type or print clearly. Before completing this form, read the Request for Nursing Home Care Determination Completion Instructions (F-01020A).

SECTION I — PROVIDER INFORMATION

Name — Billing Provider

Billing Provider's Medicaid Provider Number

National Provider Identifier

Address — Provider (Street, City, State, Zip Code)

Name — Nursing Home Contact Person

Telephone Number — Nursing Home Contact Person

SECTION II — RECIPIENT INFORMATION

Name — Recipient (Last, First, Middle Initial)

Recipient Medicaid Identification Number

Address — Recipient (If Different from Provider Address — Include Street, City, State, and Zip Code)

Social Security Number — Recipient

Date of Birth — Recipient

Gender — Recipient

Male

Female

Requested Payment Effective Date

Discharge Date

Minimum Data Set (MDS) Submittal

- Minimum data set submitted or will be submitted.
 No MDS will be submitted.

For cases where no MDS will be submitted, attach the physician's orders. List other attachments, as necessary.

SECTION III — DIVISION OF QUALITY ASSURANCE INFORMATION

Self-Reported Level of Care for Staffing Purposes

ISN

SNF

ICF-1

ICF-2

DD1a

DD1b

DD2

DD3
