

DIVISION OF HEALTH CARE FINANCING AND POLICY – NEVADA MEDICAID
ICF/IID TRACKING FORM
TO BE SUBMITTED WITHIN 72 HOURS OF ANY OCCURRENCE LISTED BELOW
FOR MEDICAID ELIGIBLE INDIVIDUALS ONLY

Recipient's Last Name: _____ First Name: _____ MI: _____

Medicaid Billing #: _____ Date of Birth: _____

SECTION I

AUTHORIZATION INFORMATION

Attachments Included

Facility Name: _____

Provider Number: _____

Facility Admission Date: _____

Resident Admitted From: _____

Dates of Stay: From _____ To _____

Reason for Eligibility Status Change Request:

Admission Readmission Discharge Medicaid Eligibility Determination ** Annual Continued Stay Review

SECTION II

DISCHARGE INFORMATION

Discharge Date: _____

Discharge Reason:

Home Community Based Living Hospital Transfer to another ICF/IID facility Death

Discharge location: _____

Form Completed By: _____ Date: _____

(Please print legibly)

Fax completed form to: QIO-like Vendor - HPES (Hewlett Packard Enterprise Services) 866-480-9903

Failure of the facility to submit this tracking form within 72 hours of any occurrence listed above may result in a delay or denial of payment.

****Annual Continued Stay Reviews: Fax completed form and attachments to DHCFP, Continuum of Care Unit (775) 687-8724 or mail to Division of Health Care Financing and Policy, 1100 E. William St., Suite 101, Carson City, NV 89701**

Attn: Continuum of Care Unit