CONFIRMATION PAGE
Please Print - Thank you for your submission

DIVISION OF HEALTH CARE FINANCING AND POLICY – NEVADA MEDICAID

NURSING FACILITY TRACKING FORM

To be submitted within 72 hours of any occurrence listed below for Medicaid Eligible individuals only

This form is to be used **only** if Medicaid is the primary payment source for this nursing facility stay. Failure of the facility to submit this tracking form within 72 hours of any occurrence listed below may result in payment delays or denials.

Please fax to Long Term Support Services Unit: 775-687-8724

Medicaid Billing #: _____ Social Security #: _____ Date of Birth: _____

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

Facility Name: _____ Provider #: _____

SECTION I

ADMISSION INFORMATION: Nursing Facility Admission Date: _____

Does this resident have a PASRR Level I Identification screening and PASRR Level II Evaluation (if applicable) completed prior to this admission date? _____

If yes, Indicate completion date: PASRR Level I: _____ PASRR Level II: _____

If the PASRR is time limited, indicate the limitation date: _____

Does this resident have a Level of Care (LOC) screening? _____ If yes, indicate completion date: _____
If the LOC is time limited, indicate the limitation date: _____

SECTION II

PAYMENT INFORMATION: Date you are requesting Medicaid Payment to begin: _____

REASON FOR PAYMENT REQUEST: _____

Indicate the Service Level Category for this resident: _____

SECTION III

DISCHARGE INFORMATION: Discharge date: _____

REASON FOR DISCHARGE: _____
Transfer (name of Facility): _____
Hospice Enrollment (name of Hospice): _____
PASRR II Determination (resident discharged to): _____

Form Completed By (Please Print): _____ Date: _____

E-Mail Address: _____

Comments: _____
_____

For Official Uses Only

PASRR: _____ **LOC:** _____ **DATE COMPLETED:** _____