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

ADMISSION/PAYMENT INFORMATION ☐ Attachments Included

Facility Name: _____

Provider Number: _____

Facility Admission Date: _____

Resident Admitted From: _____

Dates of Stay: From _____ To _____

Reason for Payment Request

☐ New Admission ☐ Re-Admission ☐ Retro-Eligible ☐ Eligibility Reinstated ☐ Annual Review**

SECTION II

DISCHARGE INFORMATION

Discharge Date: _____

Reason for Discharge:

☐ Home or Community Based Living ☐ Hospital ☐ Death ☐ Transfer (to another facility):

_____

☐ Other: _____

Form Completed By: _____ Date: _____
(Please print legibly)

Fax completed form to: Nevada Medicaid's fiscal agent (866) 480-9903.
Failure of the facility to submit this tracking form within 72 hours of any occurrence listed above may result in payment delays or denials.

****Annual Reviews: Fax completed form and attachments to DHCFP, Continuum of Care Unit (775) 687-8724 or mail to the Division of Health Care Financing and Policy, 1100 E. Williams St., Suite 101, Carson City, NV 89701**
Attn: Long Term Services and Supports