Medicare Co-Payments - client needs Medicaid assistance with co-payments

COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING
STATUS OF NURSING FACILITY CARE

Original Copy	☐
Corrected Copy	☐
County Transfer Copy	☐
Change Pt. Pmt. Copy	☒
Final Discharge Copy	☐

I. CLIENT INFORMATION:

Client: _____ _____ _____
Last Name First Name MI County State ID

_____/_____ _____ _____ _____ _____
CBMS H.H. No. Cat Client D.O.B. Gender Date of Medicaid Application Patient Level-of-care

_____ _____ _____ _____
Client's Own S.S. Number S. S. Claim Number/Suffix R. R. Claim Number V. A. Claim Number

Name and Address of Responsible Party _____ Relationship _____

II: Facility Information:

Provider Number: _____

Nursing Facility: _____ Phone Number: _____

Address: _____ Medicaid Per Diem Rate $ _____

III: Financial Arrangement:

A. Patient Income

Soc. Sec.	1423.00
SSI	
RR	
VA	
Interest	
Other	
Total Income	1423.00

B. Monthly Income Adjustments

Personal Needs	50.00
Trustee/Maintenance Fees	
Income Taxes	
Community Spouses Allowance	
Dependent Care Allowance	
Home Maintenance Allowance	
Other * (See Note Below)	
Total Deductions	50.00

C. Patient Payment Calculations

Total Income	$ 1423.00
Total Deductions	$ 50.00
LTC Insurance payment	$
Patient Payment	$ 1373.00

* If patient payment is -0-, give reasons:

_____

Admit Month	$
First Full Month	$
2nd Month	$

☐ Check If Client has Health Insurance

* Note: Medicare Part B Premium deductible for the 1st and 2nd month, Medicare Part D continuous, if applicable.

D. Change in Patient Payment

Month 5/12	$ 1373.00
Month	$

IV. We Request Medical Authorization for Medicaid Nursing Facility Care for the Above Patient:

☒ Original Admission Date to Nursing Facility _____
Admitted to Medicaid 5/6 20 12
From: Home ☐ Medicare ☒
Hospital ☐ Hosp Name _____
Readmitted to Medicaid _____ 20 _____
From: Home ☐ Medicare ☐ NF ☐ LOA ☐ YTD Tot _____
Hospital ☐ Name _____
Other ☐ Specify _____
Admitted to Medicare _____ 20 _____
From _____ No. of Days _____

☐ or original date hospitalized _____
Discharged _____ 20 _____
To: home ☐ Address _____
Days in hospital _____ # Days in NF _____
Medicare ☐ NF ☐ LOA ☐ YTD Total _____
Other ☐ Specify _____
Died _____
Place of Death _____

_____
Signature of Authorized NF Representative

V. County Transfer: (*This section is always completed by a county department staff*)

Date transferred out _____ 20____ From _____
County

Date transferred in _____ 20 ____ To _____
County

VI. County Transfer: (*This section is always completed by a county department staff*)

Approved: _____
Discontinued: _____
Denied: _____
Effective Date: 5/6 20 12

Comments:
May 1-5 = 5 x 144.50 = 722.50 Medicare co-payment
May 6-31 = 1373.00 - 722.50 = 650.50 Custodial days

_____ _____ _____
County Technician Phone Date

Transmission of this form through email requires encryption and password protection.

EXAMPLE