FEE-FOR-SERVICE (FFS) OUT-OF-STATE NURSING FACILITY PLACEMENT REQUEST FORM

Member Name	*Date of Birth*	*AHCCCS ID #*

SECTION A: TO BE COMPLETED BY THE CASE MANAGER

TRIBAL CONTRACTOR: _____

CURRENT RESIDENCE/PLACEMENT:

_____

DIAGNOSIS/CONDITION NECESSITATING THIS PLACEMENT: _____

_____

DISTANCE FROM NF TO NEAREST FAMILY: _____

LEVEL OF INVOLVEMENT BY FAMILY: _____

_____

DESCRIPTION OF FACILITY'S PROGRAM(S) THAT MAKES THIS PLACEMENT APPROPRIATE FOR THE MEMBER:

_____

_____

INFORMATION ABOUT AZ NFS RULED OUT FOR THIS MEMBER: _____

_____

PLAN FOR MEMBER'S RETURN TO AZ PLACEMENT:

_____

_____

INDICATE REQUESTED NURSING FACILITY: _____

_____

☐ **San Juan Manor**
806 W. Maple
Farmington, NM 87401
Provider ID # 841826

☐ **Four Corners Care Ctr**
818 North 400 West
Blanding, UT 84511
Provider ID# 161406

☐ **Bloomfield Nursing**
803 Hacienda Lane
Bloomfield, NM 87413
Provider ID# 825316

☐ **Red Rocks Care Ctr.**
3720 Church Rock Rd.
Gallup, NM 87301
Provider ID# 820632

PCP NAME: _____ **AHCCCS PROVIDER ID:** _____

CASE MANAGER: _____ **DATE:** _____

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SECTION B. TO BE COMPLETED BY AHCCCS

AHCCCS approvals are generally given for six month intervals. The case manager must submit a new Placement Request form for renewal if the out-of-state placement is expected to continue beyond the initial approval time period. ***Requests for renewals must be submitted prior to the expiration of the previous approval.***[1]

☐ **APPROVED**

FROM DATE	*TO DATE*	*NAME AND TITLE*	*DATE*

☐ **DENIED**

DENIAL DATE	*AHCCCS MEDICAL DIRECTOR OR DESIGNEE*	*DATE*