AHCCCS MEDICAL POLICY MANUAL
FEE-FOR-SERVICE (FFS) OUT-OF-STATE NURSING FACILITY PLACEMENT REQUEST FORM

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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Effective Date: 10/01/17
Revision Date: 07/25/17
AHCCCS MEDICAL POLICY MANUAL

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

PLACEMENT REQUEST FORM

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Date of Birth</th>
<th>AHCCCS ID #</th>
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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.**

- [ ] APPROVED
  - FROM DATE
  - TO DATE
  - NAME AND TITLE
  - DATE

- [ ] DENIED
  - DENIAL DATE
  - AHCCCS MEDICAL DIRECTOR OR DESIGNEE
  - DATE

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