Nursing Home Bed Hold

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bed hold

This section must be completed and submitted to Lakeland Care Inc, (LCI) within 24 hours from when the member leaves the facility and does not return within 24 hours.

Medicaid certified nursing homes are eligible to receive bed hold payment if their census is at or above 94% occupancy for the previous month or have had eight vacant beds or less in the previous month to qualify for bed hold coverage.

Capacity report for prior month: \_\_\_\_\_\_\_\_\_\_\_\_

 Does this meet MA census for bed hold payment: Yes [ ]  No [ ]

LCI member name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date LCI member left facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Leaving/Absence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Facility if placed elsewhere: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected length of absence:

 [ ]  Less than 2 weeks

 [ ]  Greater than 2 weeks

 [ ]  Permanent

 [ ]  Unknown

Date of Return, if known: \_\_\_\_\_\_\_\_\_\_\_\_

LCI IDT staff name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE FAX COMPLETED FORMS TO:**

Provider Contracting Assistant @920-906-5103

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This section to be completed by the Provider Contracting Assistant:

Is bed hold in compliance of Medicaid NH regulations: Yes [ ]  No [ ]

Internal Directions: Provider Contracting Assistant receives this form and forwards to appropriate IDT staff to enter a bed hold authorization. Date: \_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_