



**TEFRA MEDICAID
NURSING FACILITY LEVEL OF CARE**

SECTION ONE: Identifying Information (To be completed by Care Coordinator)

Care Coordinator Name:	Agency Name and Mailing Address:	Phone Number(s):	Email:
<input type="checkbox"/> Initial (New)	<input type="checkbox"/> Reassessment	Date of Assessment: (Date child seen/evaluated by care coordinator)	
Name of Child: (Last, First)		Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent(s) Name:	Address: (Physical and Mailing)		Phone Number(s):

SECTION TWO: Physician's Evaluation (To be completed by child's physician)

Physician Name: (Please Print)	Physician Address and Phone:	Date of last office visit:	Number of office visits or MD contacts (phone, email, etc) in last twelve months:
Primary Diagnosis:		Secondary Diagnosis:	
Medications: (include dosage and frequency)		Is child referred to any specialists? If yes, list name and specialty:	
Physician Signature:		Date:	

Note: This page is to be completed and signed by the Care Coordinator

SECTION THREE: Support Plan

(To be completed for both initial requests and yearly renewal requests)

Note: If more room is needed please use separate piece of paper and attach to form.

List current nursing needs: (Nursing needs are defined as any services the child needs that can only be provided by licensed nursing personnel i.e. ventilator support, feeding tubes, speech therapy, etc.)

Rehabilitation goals: Maintenance or Active (Note if Active, list goals, progress and projected time frames)

Discharge Plan: Yes No (Note: If Yes, State Plan with Time Frame. If No, indicate why not)

SECTION FOUR: Annual Review of Medical Needs

(To be completed for yearly renewals only)

Major medical problems since last review: (List dates, duration, and treatment(s))

Number of hospitalizations since last review: (List hospital, date(s) of hospitalization, and reason)

Since last review have there been any unusual occurrences in child's life? Yes No, If yes, please explain and list dates of occurrence

**SECTION FIVE:
Medical Documentation**

Relevant medical and/or development documentation from the past year is attached to the form Yes No
If NO, please explain why: (Note: Comagine Health cannot make a determination without medical documentation supporting the claims on this form.)

Care Coordinator Signature:

(By signing this form you are stating that all claims on this form are true and accurate)

Date:

Please submit completed form with attached medical and/or developmental documentation to: Comagine Health (Attn: TEFRA Nurse)
741 Sesame St., Suite 100
Anchorage, AK 99503

Questions: Contact TEFRA Nurse at:
(907) 550-7600, opt 3 (In Anchorage)
1-888-578-2547, opt 3 (Outside Anchorage)