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:
☐ Initial (New)	☐ Reassessment	Date of Assessment: (Date child seen/evaluated by care coordinator)	
Name of Child: (Last, First)		Date of Birth:	Sex: ☐ Male ☐ 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)