Print Form

BHSF Form 142
Rev. 07/12
Prior Issue Obsolete

Louisiana Department of Health and Hospitals
Medicaid Program
Notice of Medical Certification

SSN:_____ Date of Birth:_____ Medicaid No:_____

To:_____

Home Address:_____

Facility/Provider/Support Coordinator Name:_____ Vendor No:_____

Facility Address:_____ Parish:_____

Nursing Facility or Intermediate Care Facility

- Eligibility must be approved prior to admission to Nursing Facility. Prior approval is valid for 30 days for Nursing Facility Admission. If admitted within 30 days, decision is valid until discharged. If not admitted within 30 days of decision, a new decision is needed.
- This decision relates to medical eligibility only and is separate from a decision on financial eligibility for Medicaid.

I. ☐ A. Approved for Medicaid/Private medical eligibility services effective_____.
☐ Level II decision pending. Level of Care:_____

☐ B. Approved for Medicaid medical eligibility services for a temporary period effective_____ through_____. Level of Care:_____

Please check:
☐ MD/Physician involvement
☐ Treatment/Conditions
☐ Skilled Therapies
☐ Hospital Exemption
☐ TDC
☐ NRTP
☐ Other:_____

☐ C. Not Approved/Denied – Does not meet Medicaid medical eligibility requirement.

☐ D. ICF/DD decision pending-additional information needed: _____

Agency Representative_____ Date:_____

OCDD/OAAS Office Address_____

II. If item F, G, or H is marked, disregard Section I decision.

☐ E. Level II decision is not required.

☐ F. Approved for admission by Level II Authority effective_____.

☐ G. Approved for admission by Level II Authority for a temporary period effective_____ through_____.

☐ H. Not Approved – Admission Denied by Level II Authority.

Agency Representative_____ Date:_____

OCDD/OBH Office Address_____

III. WAIVER/PACE

☐ A. Approved Medicaid waiver criteria for_____ Waiver services effective_____.

☐ B. Not Approved - Does not meet Medicaid medical eligibility.

☐ C. Vendor Payment May Begin Date:_____

Agency Representative/Support Coordinator:_____Date:_____

OAAS or OCDD Regional Office or OBH State Office:_____

OAAS or OCDD Regional Office or OBH State Office Address:_____

CC: ☐ Facility/Provider ☐ Office of Behavioral Health ☐ OAAS ☐ OCDD
☐ Medicaid Long Term Care Unit (specify Parish): _____
☐ Other (specify): _____