DSHS

Home and Community Living Administration (HCLA)
Developmental Disabilities Administration (DDCA)

Nursing Facility Notice of Action

To be completed by nursing facility or DDA institution.

TO: Classic Medicaid cases FAX to DSHS: 1-855-635-8305

MAGI Medicaid cases FAX to Health Care Authority (HCA): 1-866-841-2267

Codes for classic and MAGI programs are in the 15-031 instructions.

Client Name: Last, First, Middle Initial (MI)	
Gender ☐ Male ☐ Female ☐ Other:	Date of Birth
Provider Number, if a Nursing Facility (NF)	
DSHS ACES Client ID (required for submission)	
Effective Date of Action	

Section I: Type of Action

☐ 1. Discharged / Transferred
☐ 2. Deceased
☐ 3. Admit
☐ 4. Social / therapeutic leave exceeds 18 days in calendar year
☐ 5. Change in payment status (includes Medicare to Medicaid, Managed Care admission and end dates, Hospice, etc.)
☐ 6. Readmit to Title XIX certified facility from hospitalization

If discharged or deceased checked, complete the following information:

Amount of Refund	Name on Refund

Section II: Discharge / Transfer Information

If Discharged / Transferred is checked in Box 1 above was checked, complete the following:

☐ 1. Home
☐ 2. Hospital
☐ 3. Nursing Facility
☐ 4. Assisted Living
☐ 5. Adult Family Home
☐ 6. Away without leave
☐ 7. Institution - DDA ICF – IID, DDA state facility (RHC)
☐ 8. DDA ICF – IID Group Home
☐ 9. Hospice / Hospice Care Center
(The Medicare / Medicaid Hospice provider must also submit HCA 13-746 Medicaid Hospice Notification to report changes per the Hospice billing guide.)
☐ 10. Other (specify):

Name of New Facility			Telephone Number (include area code)
Street Address	City	State	Zip Code
Mailing Address, if different than above	City	State	Zip Code

Section III: Reason for Action; Indicate Date:

☐ 1. Apple Health Managed Care rehabilitation / skilled nursing - admission / start date
☐ 2. Apple Health Managed Care rehabilitation / skilled nursing - coverage ends or prior authorization ends
☐ 3. Hospice admission / election (indicate hospice agency information in comments)
☐ 4. Hospice revocation
☐ 5. Private pay to Medicaid
☐ 6. Medicare to Medicaid
☐ 7. Medicaid to private pay
☐ 8. Medicaid to Medicare
☐ 9. Not in need of Nursing Facility Care

Section IV: Comments

Nursing Facility Representative	Date	Telephone Number (include area code)
Name of Facility Reporting the Change		Telephone Number (include area code)
Street Address	City	State Zip Code

Barcode label

15031

Nursing Facility Notice of Action
DSHS 15-031

Instructions

- This form is used by:
  - Nursing Facilities (NF) or Developmental Disabilities Administration (DDA) institutions to report changes to the DSHS financial eligibility worker for active Medicaid programs. Reporting changes promptly will enable correct financial eligibility, award letters and alert the DSHS financial eligibility workers of discharges or change in status
  - The HCA NF billing unit on active modified adjusted gross income (MAGI) Medicaid clients.
- Forms submitted without an ACES client ID won't be processed. All active Medicaid clients will have an ACES client ID and the medical coverage group in the provider inquiry function of ProviderOne.
- It's important to indicate the ProviderOne provider ID, facility name and address as facilities may have similar names.
- Always indicate the effective date of any reported change.
- For additional instructions and medical coverage group desk tool, consult the Nursing Facilities Billing Guide (https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules#n).
- The NF is required to get pre-approval from the Managed Care Organization (MCO) if the Medicaid client is active with an MCO or was active with an MCO at the time of hospital/facility admission.

For clients active on one of the following "classic" medical coverage groups: A01, A05, D01, D02, D26, G03, G95, G99, L01, L02, L04, L21, L22, L24, L31, L32, L41, L42, L51, L52, L95, L99, S01, S02, S08, S95, S99 and T02, FAX this form to DSHS at 1-855-635-8305.

For clients active under the following MAGI medical coverage groups: N01, N02, N03, N05, N10, N11, N13, N23, N31, N33, K01, K95, or K99, FAX this form to the HCA Claims Processing NF Unit at 1-866-841-2267.

Do not use this form to apply for Medicaid Long-Term Services and Supports. Consult the Health Care Authority Applications for LTSS page (https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/applications-ltss) for individuals who are not active on a Medicaid Program.

Do not use this form to request a social service functional assessment from Home and Community Services (HCS). This form is used only to report changes to the financial eligibility worker that may affect Medicaid eligibility.

Contact HCS social service intake to request a functional assessment for nursing facility services or discharge services and ongoing supports in the community at 1-877-429-7019 or FAX the DSHS 10-570 Intake and Referral request form (https://www.dshs.wa.gov/sites/default/files/FSA/forms/word/10-570.docx) to 1-855-635-8305.

Section I: Type of Action
- Select the appropriate box
- For boxes 2 through 6 enter the effective date the action took place

Section II: Transfer / Discharge Information
- If you selected box 1 in section one then:
  - Select appropriate box
  - Enter the effective date the action took place

Section III: Reason for Action
- Enter the effective date the action happened
- Select appropriate box

Section IV: Comments
Enter any comments to clarify the actions marked in section one through three.