

**CONTINUED STAY
SKILLED NURSING EXTRAORDINARY CARE
for Wyoming EqualityCare**

Extraordinary Recipients: MDS Activities of Daily Living Sum score of ten (10) or more and require special care or clinically complex care as recognized under the Medicare RUG III classification system for those conditions which have been prior authorized by the Department.

Note: Certification DOES NOT guarantee payment or client eligibility

Date requested _____
 Admission date _____
 Hospital _____
 Hospital EqualityCare ID # _____
 Hospital UR rep _____
 Phone # _____
 Fax # _____

For APS Healthcare Use Only

Date received _____
 Approved _____ Approved YTD _____
 Denied _____
 Certified Through _____
 Reviewed By _____
 Auth # _____

The facility has agreed to share the status of the authorization with the member

PATIENT INFORMATION

Name _____ EqualityCare ID # _____

Please include current: 1) MDS assessment 2) Progress notes 3) Nursing Care Plan 4) MD orders

Ventilator Dependent? Y / N

New ICD-9-CM code(s) (provide ALL code numbers as well as diagnosis names)

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

HCPCS code(s) (provide ALL code numbers as well as diagnosis names)

1. _____ 4. _____
 2. _____ 5. _____
 3. _____ 6. _____

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928

Forms can be found on-line at www.wyoming.apshealthcare.com

**WYOMING NURSING FACILITY
EXTRAORDINARY CARE
RATE REQUEST FORM**

Patient Name: _____
 Medicaid ID #: _____
 Facility: _____
 Projected Time Period: _____

Per Wyoming Medicaid Rules, Chapter 7, Section 22 (a), the negotiated rate determined is to cover the cost of medically necessary services and supplies that are not included in the Nursing Facility per diem rate.

REQUESTED NEGOTIATED RATE:

<u>Services under Fee Schedule:</u>			Negotiated Rate per Day
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Ventilator Care	Check box if applies: <input type="checkbox"/>	\$ 435.00	\$ -
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Additional Staffing:

Staff Time (list number of 1-1 hours required per day that are above standard care)

RN	_____	\$ 27.28	\$ -
LPN	_____	\$ 18.76	\$ -
CNA	_____	\$ 12.22	\$ -

Additional Services required (Invoices must accompany request to be considered):

Equipment (list type and cost/day):

_____		\$ -
_____		\$ -

Medical Supplies (list items and cost/day):

_____		\$ -
_____		\$ -

Wound Care (list items):

Wound VAC rental	Cost/day =	_____	\$ -
Wound VAC Supplies:			
Dressing Kits ¹	Cost for 15 kits =	_____ / 30	\$ -
Canisters ²	Cost for 10 canisters =	_____ / 30	\$ -
Other (specify) _____	Cost/day =	_____	\$ -
Other (specify) _____	Cost/day =	_____	\$ -

	Sub-total Negotiated Rate	\$ -
	Current Nursing Facility Per Diem Rate	\$ -
	Net Extraordinary Care Rate	<u>\$ -</u>

¹ Maximum coverage of 15 Kits per month.

² Maximum coverage of 10 Canisters per month.