

Michigan Department of Community Health  
**COMPLEX CARE PRIOR APPROVAL – REQUEST/AUTHORIZATION  
 FOR NURSING FACILITIES**

PRIOR AUTHORIZATION NUMBER

Fax: MDCH Program Review Division (517) 241-7813

**The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.**

**SECTION I:**

Provider's Name	NPI Number	Phone Number
Provider's Address (Number, Street, Ste., City, State, Zip)		Fax Number
Beneficiary's Name (Last, First, Middle Initial)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date
		mihealth Card Number

**SECTION II: CARE STAFFING AND SUPPLIES**

List the average number of nursing hours and supplies, vent, etc. required for this beneficiary's care that EXCEED the standard level of care and the corresponding rate of pay. *Attach additional information if necessary.*

Excess Nursing Hours	Charges Per Hour/Day	Total
RN _____ Hours Per Day	\$ _____ Per hour	\$ _____
LPN _____ Hours Per Day	\$ _____ Per hour	\$ _____
Aide _____ Hours Per Day	\$ _____ Per hour	\$ _____
Excess Daily Supplies		
Medical Supplies (e.g., vent)		
1. _____	\$ _____ Per day	\$ _____
2. _____	\$ _____ Per day	\$ _____
3. _____	\$ _____ Per day	\$ _____
4. _____	\$ _____ Per day	\$ _____
<b>TOTAL</b>		\$ _____

**SECTION III: ADDITIONAL COMMENTS**

(250-Character Limit).

**SECTION IV: PROVIDER CERTIFICATION**

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

\_\_\_\_\_  
 Provider Signature

\_\_\_\_\_  
 Date

**MDCH USE ONLY**

Review action: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>	Consultant remarks		
<b>Start Date</b>	<b>End Date</b>	<b>Units – Number of Days</b>	<b>Total Daily Rate</b>
			\$

\_\_\_\_\_  
 Consultant Signature

\_\_\_\_\_  
 Date