Michigan Department of Health and Human Services
Program Policy Division
PO Box 30479
Lansing MI 48909

Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

April 28, 2016

<Provider Name>
<Provider Address 1>
<Provider Address 2>
<Provider City> <State> <zipcode5-zipcode4>

Medicaid Provider Identification Number:

Dear Nursing Facility Administrator:

RE: Medicaid Provider Identification (ID) Number

The purpose of this letter is to inform you of your facility's seven-digit Medicaid Provider ID number in the Community Health Automated Medicaid Processing System (CHAMPS) and proper use of this number. The Medicaid Provider ID number, along with your National Provider ID (NPI) is needed on the Facility Admission Notice (MSA-2565-C) and must be provided to hospices rendering services in your facility. Your facility's Medicaid Provider ID number is located in the upper right-hand corner of this letter.

Use of the Medicaid Provider Identification Number and National Provider ID (NPI)

1. Your facility's Medicaid Provider ID number is necessary for completion of the MSA-2565-C, box 12.b. When admitting a Medicaid beneficiary to a nursing facility, this form must be submitted to the local Michigan Department of Health and Human Services (MDHHS) office where level of care (LOC) 02 will be added to the beneficiary file if the admission is approved. Note: Do not submit a MSA-2565-C for beneficiaries receiving hospice services in your facility.

2. Your facility's Medicaid Provider ID number and your NPI number are also necessary for use by hospice providers when enrolling a beneficiary residing in your facility into hospice.

Please provide the Medicaid Provider ID number (found in the upper right hand corner of this letter) to each hospice providing services in your facility. Providing the Medicaid Provider ID number will help to ensure proper room and board payment to your facility by your contracted hospice providers.

This Medicaid Provider ID does not take the place of your NPI number, which is also required on the MSA-2565-C and is required on the institutional form when billing for Medicaid Services. Note: When completing the MSA-2565-C the NPI field must also contain the effective date of the new NPI.

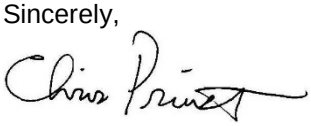
The Medicaid Provider ID number associated with a LOC 02 segment in the members eligibility file, must be that of the Provider who conducted the Level of Care Determination (LOCD) or claims may deny with one of the following adjustment reason code and/or Remittance Remark Code:

- CARC B7
- CARC 96
- RARC N216

Please retain a copy of this letter for your records.

Any questions regarding this letter should be directed to Provider Support, Michigan Department of Health and Human Services, PO Box 30731, Lansing Michigan 48909-8231 or email at Providersupport@michigan.gov. When you submit an email, please include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Sincerely,



Chris Priest, Director
Medical Services Administration

enclosure

Michigan Department of Health and Human Services

FACILITY ADMISSION NOTICE (MSA-2565-C)

INSTRUCTIONS

GENERAL INSTRUCTIONS/DISTRIBUTION:

- The MSA-2565-C serves as notice of admission of a beneficiary (or potential beneficiary). It must be completed for potentially eligible Medicaid beneficiaries of all ages.
- The facility must retain **THE ORIGINAL** of the Facility Admission Notice in the beneficiary's file. A copy **MUST** be sent to the Local MDHHS Office.
- A copy of the MSA-2565-C will be returned to the facility, noting the eligibility status and patient pay amount of the resident.

NEWBORN CHILD ELIGIBLITY

If completing the form for a newborn:

- Item 6 must state the name of the mother.
- Item 20 must state "newborn."
- A copy of the CHAMPS Eligibility Inquiry or HIPAA 271 transaction response with the mother's Benefit Plan ID information should be attached to the form; or the form must contain the County, District, Unit, Worker, and case number data from the eligibility response separated by slashes (e.g., 33/01/01/08/1234567890).

STATE-OWNED AND-OPERATED FACILITIES AND CMHSP FACILITIES

For state-owned and -operated facilities:

- Item 13 may be left blank.

Authority: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act
Completion: Is Voluntary
Penalty: None, but a medical eligibility determination would be delayed

Michigan Department of Health and Human Services

FACILITY ADMISSION NOTICE

1. Patient Name *(Last, First, Middle)*	2.Gender ☐ M ☐ F	3. Birth Date / /	4. Social Security No. - -
5. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
6. Name of Person Responsible for Patient *(Last, First, Middle)*	7. Phone No. ( ) -	8. Relationship to Patient	
9. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
10. Name of Provider	12. A. National Provider ID Number.	12. B. Medicaid Provider ID Number	
11. Provider Address *(No. & Street)*	13. Attending Physician Name		
City / State / Zip Code	14. Hospital Case No. *(If Applicable)*		

15. Type of Facility *(Check ONE)*

☐ Hospital ☐ Long Term Care (in Hospital) ☐ Nursing Facility ☐ Psychiatric Care (in DCH Facility))
☐ Special IID Nursing Facility ☐ ICF/IID Care (in MDHHS Facility) ☐ Medical Care Facility
☐ Other (Explain) _____

16. Date of Admission / /	17. If LTC Facility, Specify Private Pay Rate to facilitate determination of Medicaid eligibility $ _____ per diem amount	18. Is this Admission Likely to be 30 days or Longer? ☐ NO ☐ YES (If YES, Estimate Total Length of Stay) _____

19. Present Status of Patient *(Check ONE)*

☐ Still a Patient ☐ Discharged (Date): / / ☐ Deceased (Date): / /

20. Primary Diagnosis	21. Secondary Diagnosis

22. Patient Admitted to Facility From: *(Check ONE)*

☐ Home ☐ Long Term Care Facility/Unit ☐ AFC/ Home for the Aged ☐ Other (Specify) _____
☐ Hospital (Enter applicable dates) Admission Date / / Discharge Date / /

23. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable

☐ Medicare ☐ No Other Insurance Coverage Available
☐ Private Health Insurance (Complete Items 24 thru 30 below) ☐ Private LTC Coverage (Complete Items 31 thru 37 below)

24. Name of MI Health Link Integrated Care Organization		31. MI Health Link Integrated Care Organization Provider I.D. Number	
25. Name of Policyholder (Private Health Ins.)	26. Policyholder's SS No. - -	32. Name of Policyholder (Private LTC Ins.)	33. Policyholder's SS No. - -
27. Name of Insurance Company		34. Name of Insurance Company	
28. Location (City) / State / Zip Code		35. Location (City) / State / Zip Code	
29. Group / Policy Number	30. Cert. / Contract No.	36. Group / Policy Number	37. Cert. / Contract No.

PATIENT CERTIFICATION

I certify that the information furnished by me in applying for skilled nursing facility, other long term care, or hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section **10** above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

38. Signature of Patient or Patient's Representative Date Signed / /	39. Signature of Person Completing This Form Date Signed / /

STATEMENT OF ELIGIBILITY (To be completed by MDHHS for MA eligibility)

Eligibility is:

☐ **DENIED** (Contact Patient or Patient's Representative for Explanation) ☐ **APPROVED** (see the Billing Information below)

Eligible Person's Name	Program	Grantee Name			
Recipient ID No.	MA Eligibility Effective Date	Grantee Client ID No.			MDHHS Case No.
Patient Pay Amount $	Patient Pay Amt. Effective Date	County	District	Section / Unit	Worker Name
Insurance, Medicare, Third Party Name		Signature of Worker			

MSA-2565-C (4/16) Previous editions are obsolete.