REQUEST FOR AUTHORIZATION OF PRIVATE ROOM SUPPLEMENTAL PAYMENT FOR NURSING FACILITY

Michigan Department of Health and Human Services

This is my written request for authorization of supplemental payment for a single room for:

Name of Beneficiary/Resident	Medicaid ID Number
Facility Contact	Facility Telephone Number - -
Facility Name	Facility Fax Number - -
Facility Address	

The basis for this request is:

☐ I believe a single room is medically necessary. (If medically necessary, the Medicaid daily rate already pays for a single room.)

☐ I believe a single room is not medically necessary, but is needed for the following reason(s):

_____

_____

I understand that I must accept responsibility for paying the difference between the facility's two-person room and single room rates that are listed below. I will pay any difference in the rates that may change over time, as long as a single room is needed.

Two-person room rate: $ _____ per day

Single room rate: $ _____ per day

Printed Name of Requestor	Telephone Number - -
Address	Relationship to Beneficiary/Resident

Signature of Requester	Date

MAIL TO: Long Term Care Services
Michigan Department of Health and Human Services
PO Box 30479
Lansing, MI 48909-7979

FAX TO: 517-241-8995

Note: If no response is received within 10 working days, contact 517-241-4293.