Wyoming Department of Health

Telligen®

ADMISSION CERTIFICATION

SKILLED NURSING EXTRAORDINARY CARE

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.

Required Documentation	1. PASRR & Date	2. MDS assessment 3. History & Physical (<1 yr old)	4. Drug history 5. Nursing Care Plan 6. Progress notes	7. Itemized cost list 8. MD statement w/Dx & expected LOS

Ventilator Dependent?: ☐ Yes ☐ No

Note: Preadmission certification DOES NOT guarantee payment or client eligibility

Date requested:	**For Telligen Use Only**
Admission date:	Date received:
Facility:	Approved:
Facility NPI #:	Certified Through:
Facility UR rep:	Denied:
Phone #:	Reviewed By:
Fax #:	Authorization #:

Attending/referring physician (first and last name):		
Physician Wyoming Medicaid ID #:		Phone #:
Address:		
PATIENT INFORMATION		
Name:		Medicaid ID #:
Address:		Phone #:
DOB:	SS #:	Sex: ☐ Male ☐ Female
ICD-10-CM code(s) (provide ALL code numbers as well as diagnosis names):		
1. 2. 3.		4. 5. 6.
HCPCS code(s) (provide ALL code numbers as well as diagnosis names):		
1. 2. 3.		4. 5. 6.

Fax form to Telligen toll-free @ 1-877-897-0111
Forms can be found on-line at wymedicaid.telligen.com

Wyoming Department of Health

Telligen®

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			Negotiated Rate per Day
Services under Fee Schedule			
Ventilator Care: Includes supplies, equipment and staffing time required to assist with ventilator care	Check box if applies: ☐	$435.00	
Additional Staffing Staff Time (list number of 1:1 hours required per day that is above standard care)	RN: LPN: CNA:	$40.29 $27.70 $18.05	
Additional Staffing – Please indicate what the additional staffing will be performing that is not included in the NH per diem:			
Additional Services required (An updated invoice and/or itemized list must accompany request to be considered)			
Equipment (list type and cost/day):			
Medical Supplies (list items and cost/day):			
Wound Care (list item): Wound VAC rental: Wound VAC supplies:	Cost/day = Cost for 15 kits =	/30	

Dressing Kits Canisters Other (specify): Other (specify):	Cost of 10 canisters = /30 Cost/day = Cost/day =	
	Sub-total Negotiated Rate Current Nursing Facility Per Diem Rate: Net Extraordinary Care Rate	

[1]Maximum coverage of 15 kits per month
[2]Maximum coverage of 10 canisters per month