



DC Department of Health Care Finance

Long Term Care Administration

Prescription Order Form Instructions

A Prescription Order Form is required to request an Assessment for Long Term Services and Supports as well as for Personal Care Aide Services for MCO Enrollees.

Organizations with access to DC Care Connect (DCCC) **must** upload the form. Faxed or emailed POFs will not be accepted from organizations with access to DCCC, unless:

1. It is an initial assessment for an individual not know to DC Medicaid and not in DCCC,
2. The enrollee is in within a traditional Managed Care Organization (MCO) or Child and Adolescent Supplemental Security Income Program (CASSIP), not a Dual-Special Needs Plan (D-SNP),
3. You are a hospital provider.

THREE WAYS TO SUBMIT THE POF

1. **Electronic Transmission:** Fill out the **on-line form** and click SUBMIT POF. It will be transmitted electronically to Liberty Healthcare and you will receive an email receipt of transmission.
2. **Print a completed form and upload in DCCC or FAX to Liberty Healthcare:** Fill out the **on-line form** and click PRINT POF. You can upload the request in DC Care Connect. If you do not have access to DCCC, FAX the form to 202-698-2075, or email the form to dclibertyias@LibertyHealth.com.

All referring providers must be enrolled as a DC Medicaid Provider. DHCF has a streamlined application process for ordering/referring providers which can be accessed at www.dcpdms.com by clicking "Create an account." Providers can then follow the instructions to set up an expedited enrollment package. Please note that providers may enroll as ordering/referring providers only you will not receive payment for any claims submitted and will not be part of the Medicaid-eligible providers' directory, but this will allow us to process the ePOF.

The items marked with an asterisk must be completed. If required items are not completed, you will be prompted to complete these items before you can submit the form electronically or print it out.

ORDERING Physician/APRN Signature

- All forms must be signed by the Ordering Physician or Advance Practice Registered Nurse (APRN). *Note that an exception to the signature requirement has been provided during the COVID Public Health Emergency (PHE) that was declared on March 2020. This waives the hard signature, but the RN/SW **MUST** have a discussion and obtain a telephone order to sign in leu of the MD/APRN signature*
- All referring providers must be enrolled as a DC Medicaid Provider.
- By signing the POF, the referring provider is attesting that he/she have examined this
- patient and certify that long term care services and supports are medically necessary.
- Once the MD/APRN has completed the form no edits are allowed.



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Completing the Form

SECTION I: PATIENT INFORMATION

- For individuals enrolled in DC Medicaid, the DC Medicaid Number is required. If the individual does not yet have a number, enter N/A. Full name, date of birth, address and at least one phone number are all required items and are necessary to verify the requesters identity and schedule the assessment.
- Any additional information that you may have such as a secondary phone number, permanent address if it is different than the current address, e-mail-address, current Medicaid coverage (if any) emergency contact information, and information regarding a Legal Guardian/POA.
- If the individual needs interpretive services to schedule and/or participate in the assessment this should be identified in SECTION I., where the primary language spoken is identified.

SECTION II. DETERMINING NEEDS FOR SERVICES

The patient's chronic medical conditions. Please list all medical diagnosis, including chronic medical and other relevant health care conditions. At least one medical diagnosis relating to the need for ordered services is required. This item question is required (*)

- Reason for assessment referral
 - o Indicate if this assessment is for recertification of current services, initial assessment for new patient requesting LTSS, change in condition, or request for upload of current assessment from MCO into DCCC. This item question is required (*).
 - If "Change in Condition" was checked, please complete the follow-up reason for change in condition questions to indicate how the patient's condition has changed significantly since the most recent assessment.
 - o Indicate the request type in section II. This item question is required (*).
 - o Section II also helps to identify hospital discharges for priority purpose, provides additional information for the upload request for patients transitioning from MCO to Long Term Care Fee-For-Service, and clarifies if the patient needs nursing facility placement or discharge for Home and Community Based Services (HCBS).
 - Individuals being assessed for initial entry into a nursing facility should include a completed Pre-Admission Screening and Resident Review (PASRR).

The SUBMITTING INDIVIDUAL:

In this subsection is where you will identify who is submitting the POF on the beneficiary's behalf with your name, and contact information. If the individual submitting the POF is not the contact for scheduling, please include information for the scheduling contact and any special instructions. such as " best time to contact beneficiary 1-2 pm, make sure case manager is present"

SECTION III: PHYSICIAN/APRN INFORMATION

- The physician/APRN name, address, National Provider Identification Number, telephone number, signature and date are required fields. The request for physician/APRN signature can be done either by email or fax. Please select the applicable option.
 - o Email – upon selecting email, a new field will open for the physician/APRN email address.
 - o Fax – upon selecting fax, three fields will open for physician/APRN fax number, signature, and date.