Government of the District of Columbia
Department of Health Care Finance

Out-of-State Nursing Facility Placement

Please print clearly and complete all sections.

SECTION A: BENEFICIARY						
Date:	Last Name:	First:	M.I.:	Medicaid ID:	Birth date:	Gender: ❑ M ❑ F

SECTION B: REQUESTING FACILITY				
Facility Name:	Street Address:	City:	ST:	ZIP:
Facility NPI	Phone:	Fax:		
Name of Person Completing Form:	Title			

SECTION C: DENYING FACILITY❖				
Facility Name:	Street Address:	City:	ST:	ZIP:
Phone:	Fax:			
Person Denying	Denial Reason	Date of Denial		

** (a minimum of one (1) DC facilities must be contacted and deny placement)*

SECTION D: PLACEMENT RATIONALE

Reason beneficiary is not being placed in the community. Check all that apply:

- ❑ Type or intensity of care required not available in the community
- ❑ No bed availability at this time
- ❑ Beneficiary prefers to receive care in a nursing facility outside of the District

SECTION E: BENIFICIARY AGREEMENT

Last Name	First Name
Person Responsible for making decisions on the beneficiary's behalf:	

□ I agree to out of state nursing facility placement

Signature	Date

Upload this form via the Comagine Health Provider Portal at https://comagine.org/program/dc-medicaid-um In the Healthcare Professional Drop-Down Menu select DC Medicaid-> Provider Resources-> Comagine Health Provider Portal. You may obtain assistance in registering for the Comagine Health Provider Portal by contacting providerportalhelp@comaginehealth.org.

Please attach all supporting documentation including but not limited to: PASRR; beneficiary's history and physical; discharge summary; copy of the most recent physician and nurse notes.

Revised: March 3, 2023