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| **Check the Case Request*** New Admission
* Payer Change

**Mycare Ohio Cases*** New admit long term non skilled
* New admit skilled
* Readmit long term non skilled
* Readmit skilled
* Skilled service request

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Please include the following with pre-cert request:*** Copy of MITS
* Hospital Face Sheet
* Hospital H&P
* Current Meds
* Therapy Evaluations
* Recent Therapy Notes

**Include other skills if not therapy such as:*** Wound Care
* Wound Notes
* IV Meds with Stop Date

Note: Lack of appropriate and complete documentation may result in a delayed payer determination.**Company name**Street AddressCity, State, ZIP CodePhone NumberWeb Site | To: **CPAN Pre-Cert Case Manager**Email/Scan:**precert@cpanohio.com** **(preferred)**Fax number: (513) 777-2372**Main Number**: (513) 777-2371 **After Hours:** (513) 482-0805 |
| From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Facility Admitting To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Expected Admit Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Resident Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD to be assigned at Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD address/phone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Hospital Contact #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ICD10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_www.cpanohio.com |