RI MEDICAL ASSISTANCE PROGRAM

LONG TERM CARE TURNAROUND DOCUMENT

REQUEST FOR PAYMENT FOR MONTH ____________

1. PROVIDER NUMBER
2. PROVIDER NAME

3. LN #	4. REC ID	5. LAST NAME	6. FST NM	7. DOB	8. DIAG	9. SEC DG	10. MC IND	11. PAT ACCT #	12. ATTN PROVIDER NO	13. ADMIT DATE	14. PAT LIABILITY	15. OI IND	16. CARR CODE	17. OI PAYMENT
	18. DTL	19. RPL	20. START DATE	21. THRU DATE	22. BILL DAYS	23. PAT STATUS	24. EFFECT DT	25. NEW RPL	26. LOA DAY	27. START LOA	28. END LOA			
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MEDICAID STATEMENT

AUTHORIZED SIGNATURE　　　　DATE

RPL

001 Medicare or other Third Party Carrier covered co-insurance days
002 Medicaid only covered days
003 Medicaid only covered days (State Hospital only)
004 Medicaid covered hospital only rate (State Hospital only)
005 Medicare or other Third Party Carrier fully covered days

OI IND

1 = Yes - Recipient has other insurance
2 = No other insurance

PATIENT STATUS

01 Discharged to Home or Self Care
02 Discharged/Transferred to General Hospital
03 Discharged/Transferred to another SNF
04 Discharged/Transferred to another ICF
05 Discharged/Transferred to another type of Inst. (e.g. Hospice, Rehab. Fac.)
06 Discharged/Transferred to Home under care of Home Health
30 Still a Patient
41 Expired
77 Visitation (Waiver Group Homes only)