APS HEALTHCARE
Healthy Together

equalitycare

CONTINUED STAY

SKILLED NURSING EXTRAORDINARY CARE

for Wyoming EqualityCare

***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.*

Note: Certification DOES NOT guarantee payment or client eligibility

Date requested________________________

Admission date________________________

Hospital________________________

Hospital EqualityCare ID #________________________

Hospital UR rep________________________

Phone #________________________

Fax #________________________

For APS Healthcare Use Only
Date received________________________
Approved____________ Denied____________
Certified Through________________________
Reviewed By________________________
Auth #________________

PATIENT INFORMATION

Name ________________________________ EqualityCare ID #________________________

Please include current: 1) MDS assessment 2) Progress notes 3) Nursing Care Plan 4) MD orders

Ventilator Dependent? Y / N

New ICD-9-CM code(s) (provide ALL code numbers as well as diagnosis names)

1.________________________ 4.________________________

2.________________________ 5.________________________

3.________________________ 6.________________________

HCPCS code(s) (provide ALL code numbers as well as diagnosis names)

1.________________________ 4.________________________

2.________________________ 5.________________________

3.________________________ 6.________________________

Fax form to APS Healthcare toll-free @ 1- 888- 245-1928

Forms can be found on-line at www.wyoming.apshealthcare.com

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:

Services under Fee Schedule:			Negotiated Rate per Day
Ventilator Care	Check box if applies: ☐	$ 435.00	$ -

Additional Staffing:

Staff Time (list number of 1-1 hours required per day that are above standard care)

	Hours	Rate	Negotiated Rate per Day
RN	______	$ 27.28	$ -
LPN	______	$ 18.76	$ -
CNA	______	$ 12.22	$ -

Additional Services required (Invoices must accompany request to be considered):

Equipment (list type and cost/day):

______________________ $ -
______________________ $ -

Medical Supplies (list items and cost/day):

______________________ $ -
______________________ $ -

Wound Care (list items):

Wound VAC rental	Cost/day =	______		$ -
Wound VAC Supplies:				
Dressing Kits [1]	Cost for 15 kits =	______	/ 30	$ -
Canisters [2]	Cost for 10 canisters =	______	/ 30	$ -
Other (specify)	Cost/day =	______		$ -
Other (specify)	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.

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