PHP Notification of Nursing Facility Level of Care

To be completed by Health Plan

Member Information

Last Name: _______________
First Name: ________________________
DOB: ____________________
Gender: ☐ M ☐ F
MID #: _________________

Assigned Health Plan Information (Standard or Tailored Plan)

Health Plan Name: ______________________
Health Plan Contact: _____________________
Health Plan Contact Phone Number: _________________________________
Health Plan Contact Email Address (Optional): _____________________________________

Level of Care Information:

Previous level of Care: ☐Home ☐SNF ☐ICF ☐Hospital ☐Dom ☐Other______________
If applicable, previous hospital/facility name & discharge date _________________________________
NF Level of Care Approved by PHP: ☐ Yes ☐No
Effective Date of NF Level of Care Approval: ___________

Name: ____
(Enter Name of Health Plan Representative)

Date: ____________________________________
(Enter Date of Approval)

To be completed by NF or Hospital*

Admitting Nursing Facility or Hospital Information:

Facility/Hospital Name: ______________________
Facility/Hospital Address: ________________________
NF/Hospital Contact Name: _________________________
NF/Hospital Contact Phone Number: _________________
NF/Hospital Contact Email Address: __________________
Member's admission date to facility/hospital: __________________
Member's Last 4 of SSN: ____
Authorized Representative Name, Address & Phone Number:

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*NOTE: In addition to NF, if the approval is for nursing facility level of care or a Swing Bed in a hospital, the hospital should fill out the above section.

PHP USE ONLY

INSTRUCTIONS FOR COMPLETION OF NC MEDICAID FORM 2039
HEALTH PLAN NOTIFICATION OF NURSING FACILITY LEVEL OF CARE

Section 1: **Member Information**

To be completed by the health plan, all information must be completed in this section.

1. In the “Last Name” field, enter the member’s last name
1. In the “First Name” field, enter the member’s first name
2. In the “DOB” field, enter the member’s date of birth (example*: 12/25/1960)*
3. In the “Gender” field, select the member’s gender
4. In the “MID” field, enter the member’s Medicaid Identification Number

Section 2: **Assigned Health Plan Information**

To be completed by the health plan - unless marked as optional, all information must be completed in this section.

1. In the “Health Plan Name” field, enter name of the Health Plan the member is assigned to
2. In the “Health Plan Contact” field, enter the name of person to be contacted if the local Department of Social Services has questions or requires assistance
3. In the “Health Plan Contact Phone Number” field, enter telephone number where the Health Plan contact person noted above can be reached
4. In the “Health Plan Contact Email Address” field, enter an email address where the Health Plan contact person noted above can be reached. Note: This field is optional and not required.

Section 3: **Level of Care Information**

To be completed by the health plan - unless marked as “if applicable, "all information must be completed in this section.

1. In the “Previous Level of Care” field, select the member’s level of care prior to the member’s admission to NF - *select appropriate box*
2. In the “If Applicable, Previous Hospital/Facility Name and Discharge Date” field, enter the name of the hospital/facility where the member was previously admitted and the member’s discharge date from the hospital/facility.
3. In the “NF Level of Care Approved by PHP” field, select if NF level of care was approved by the Health Plan: *select: Yes or No*
4. In the “Effective Date of NF Level of Care Approval” field, enter the effective date of NF level of care approval
5 In the “Name” field, enter the name of the Health Plan representative completing the 2039 form
6. In the “Date” field, enter the date the level of care was approved.

Section 4: **Admitting Nursing Facility or Hospital Information**

To be completed by NF or hospital, all information must be completed in this section.

NOTE*: If the approval is for NF level of care or a swing bed in a hospital, the hospital must complete Section 4.*

1. In the “Facility/Hospital Name field”, enter the name of the admitting NF or hospital
2. In the “Facility/Hospital Address” field, enter the address of the admitting NF or hospital noted above
3. In the “NF/Hospital Contact Name” field, enter name of person to be contacted at the admitting NF or hospital noted above, should the local Department of Social Services have questions or require assistance
4. In the “NF/Hospital Contact Phone Number” field, enter the telephone number where contact person for the admitting NF or hospital noted above can be reached
5. In the “NF/Hospital Email Address” field, enter the email address where the contact person for admitting NF or hospital noted above can be reached
6. In the “Member’s Admission Date to Facility/Hospital” field, enter the member’s date of admission to the admitting NF or hospital noted above
7. In the “Member’s Last 4 of SSN” field, enter the last four digits of the member’s social security number
8. In the “Authorized Representative Name, Address, & Phone number” field, enter the name, address, and phone number of authorized representative of the member

Note: The 2039 form is not a prior authorization form. After completing Sections 1 – 3 of the 2039 Form, the health plan sends the form to the admitting NF or hospital (as applicable) along with the authorization for NF services.

After the nursing facility or hospital completes Section 4 of the DHB-2039 Form, it is sent by the admitting NF or hospital (as applicable) to the local Department of Social Services that administers the beneficiary’s Medicaid benefits, within five business days of receipt.