NC DMA Physician’s Signature for authorization of level of care

This form is to verify that I have provided the information submitted on the State Approved Level Of Care Form on the NCTracks website on behalf of the recipient. I have assessed the following level of care to be appropriate for this individual:

NF_____  NF Rehab_____  Vent_____  Specialty Hospital Rehab_____  Extended Care_____  
CAP/DA Intermediate_____  CAP/DA Skilled_____  
CAP/C Skilled_____  CAP/C Hospital  PACE_____  

Recipient Information:

Name:_________________________________________  MID:_________________________________________  

Receiving Facility Name (if known): ____________________________________________________________  

Date LOC/ determination made: ________________________________________________________________  

Date of Move to facility (if known) ____________________________________________________________  

I verify that the information on the state approved level of care form is accurate and reflects the needs of the recipient regarding the above named individual.

_________________________________________  ____________________________________________  

MD Signature  Date signed

Fax this form to CSC at: (855) 710-1964  
Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp