DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH CARE FINANCE

PRESCRIPTION ORDER FORM (POF)

FOR LONG TERM CARE SERVICES AND SUPPORTS

This completed form must be uploaded to DC Care Connect or faxed to Liberty Healthcare Corporation at 202-698-2075.

This Prescription Order Form (POF) is required by the District of Columbia's Department of Health Care Finance (DHCF) to authorize Medicaid-funded long term care services and supports. Prior to submission, the following items (indicated with a **) **must** be completed.

- Patient Medicaid Number (if available)
- Patient full name
- Patient date of birth
- Patient telephone number
- Provider name
- Provider telephone number
- Patient's chronic medical conditions
- Reason for referral to assessment
- Signature of ordering physician / APRN

Please note that all referring providers must be enrolled as a DC Medicaid Provider. DHCF has a streamlined application process for ordering/referring providers which can be accessed at **www.dcpdms.com** by clicking "Create an account." Providers can then follow the instructions to set up an expedited enrollment package. Please note that providers who enroll as ordering/referring providers only will not receive payment for any claims submitted and will not be part of the Medicaid-eligible providers' directory.

SECTION I: PATIENT INFORMATION

A. **Patient DC Medicaid Number (8 digits).
If the individual is new to DC Medicaid and does not yet have a Medicaid number, please note "N/A."

B. **Patient Name (Last, First):

C. **Date of Birth (MM/DD/YYYY):

D. **Telephone Number:

E. Secondary Telephone Number:

F. ** Current Address:

G. Permanent Address (if different than above):

H. Emergency Contact Name:

I. Telephone Number:

SECTION II. DETERMINING NEED FOR SERVICES

A. **This patient has the following chronic medical condition(s) / ICD-10 diagnosis(es):

B.** Reason for referral to assessment: ☐ Hospital ☐ Reassessment ☐ Initial assessment ☐ Change in patient condition

C.** Request Type: ☐ EPD Waiver ☐ State Plan LTSS

D. Retroactive Coverage Request Effective Date (Nursing Facilities Only):

E. **If "Change in patient condition" was checked in section B, please indicate how this patient's condition has changed significantly since his/her most recent assessment:

F. Comments:

SECTION III: PHYSICIAN/APRN INFORMATION

A. **Provider Name (Last, First):

B. **Telephone Number:

C. **National Provider Identifier Number:

D. **Provider Address:

E. **Fax Number:

I have examined this patient and certify that long term care services and supports are medically necessary.

**Signature of Ordering Physician/APRN:

Date:

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