|  |
| --- |
| section A: BENEFICIARY for whom out-of state placement sought |
| Last Name: First: MI:   | Date of Request: |

|  |
| --- |
| section B: NURSING FACILITIES |
| Facility Name 1:  | Person Contacted: | Date of Contact: | Admission Approved?❑ Yes ❑ No |
| Comments: |  |  |  |
| Facility Name 2: | Person Contacted: | Date of Contact: | Admission Approved?❑ Yes ❑ No |
| Comments: |  |  |  |
| Facility Name 3: | Person Contacted: | Date of Contact: | Admission Approved?❑ Yes ❑ No |
| Comments:  |
| Facility Name 4:  | Person Contacted: | Date of Contact: | Admission Approved?❑ Yes ❑ No |
| Comments: |  |  |  |
| Facility Name 5: | Person Contacted: | Date of Contact: | Admission Approved?❑ Yes ❑ No |
| Comments:  |

**Upload this form** via the Qualis Health Provider Portal at [www.qualishealth.org](http://www.qualishealth.org). In the Healthcare Professional Drop-Down Menu select DC Medicaid-> Provider Resources-> Qualis Health Provider Portal. You may obtain assistance in registering for the Qualis Health Provider Portal by contacting providerportalhelp@qualishealth.org

**(Please Note: For ventilator or dialysis requests, only 2 nursing home denials are required)**

Revised June 20, 2017