Medical Care Transaction Form

TO: Department of Health & Mental Hygiene
Medical Care Operations Administration
201 West Preston Street, SS-18
Baltimore, Maryland 21201
☐ Nursing Home Section ☐ Chronic Care Section

Re: Name: _____

M.A. No. _|_|_|_|_|_|_|_|_|_|_

FROM: _____
Nursing Home/Chronic Facility

_____
Street Address

_____
City State Zip Code

* UCA USE ONLY
Level of Care Eff. _____|_____|_____
Mo. Day Yr.
☐ NFS ☐ Skilled
☐ Chronic
_____
Utilization Control Agent
_____ _____
Authorized Signature Date

Cancel Pay Effective _____|_____|_____
Mo. Day Yr.
☐ No longer NFS
☐ No longer Chronic Care

Begin Pay Effective _____|_____|_____
Mo. Day Yr.
☐ * Admitted to Chronic Care
☐ * Admitted to NFS

_____ _____ _____
Signature of Facility Administrator MCOA Date Telephone Number

DHMH 259 (Revised 01/09)

White – LDSS/DEWS Yellow- LTCF Pink- UCA