**Report of Administrative Days**

**MDH 1288**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient First Name | |  | | | | | Patient Last Name |  | | |
| Medical Assistance # | | |  | | | | Date of Birth |  | | |
| Hospital Name |  | | | | | | MA Provider Number | |  | |
| Diagnosis (Admission) | | | |  | | | Diagnosis (Discharge) | |  | |
| Patient Admission Date | | | |  | | | Begin Date for Administrative Days | | |  |
| UCA Case ID(s) Associated with Patient | | | | | |  | | | | |
| Reason for Extended Stay | | | | |  | | | | | |

Other Level of Care Requests and Discharge Planning Log – Please note all efforts to seek placement, the date in which contact was made, and the result of that contact on page 2 of this form.

|  |  |  |  |
| --- | --- | --- | --- |
| Discharged to |  | | |
| Discharge Date |  | | |  |  |
| Length of Stay |  | | Number of Administrative Days Requested | |  |
| Review Coordinator Signature | |  | | Date Signed |  |

------------------------------For Utilization Control Agent (UCA) Use Only---------------------------------

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Approved Administrative Date Span | | |  | | | | |
| Administrative Days Approved | |  | | Administrative Days Denied | | |  |
| UCA Signature |  | | | | Date Signed |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Other Level of Care Requested** (Please “X” if applicable) | | | | | | | |
| Nursing Facility Level of Care | |  | Chronic Level of Care | |  | Pediatric Level of Care |  |
| UCA Case ID(s) Associated with Level of Care Request | | | |  | | | |
| Date Level of Care Approved |  | | | | | | |

**Discharge Planning Log**

|  |  |  |
| --- | --- | --- |
| Date | Facility Name | Notes |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

If more space is needed, please attach additional notes in a similar format.

Please adhere to program requirements listed below as well as Hospital Transmittal 257. Failure to provide the MDH 1288 form timely will result in a denial of administrative payment.

* For patients in an acute hospital, a minimum of two calls per day showing placement efforts are required, excluding weekends and holidays. Please see COMAR 10.09.92.07 for more information.
* For patients in a chronic or special pediatric hospital, placement activity must begin on the date for which level of care is no longer met and must be conducted no fewer than 3 days per week thereafter. The MDH 1288 form must be submitted every 14 days. Please see COMAR 10.09.93.08 and COMAR 10.09.94.06 for more information.