

LONG TERM CARE HOSPITAL (LTCH) SITE NEUTRAL EXCLUSION FORM

Instructions:

Please type all fields. Fields with a red border are required.

PROVIDER INFORMATION

Provider Name

Provider Address

Provider Telephone & Extension

() - x
National Provider Identifier (NPI)

Provider Number (PTAN)

REQUESTER INFORMATION (IF DIFFERENT)

Requester Name

Requester Address

Requester Telephone & Extension

() - x

PATIENT & CLAIM INFORMATION

Region in which the services were provided:

Patient Name

Medicare Beneficiary Identifier (MBI/HIC)

Claim Number (DCN) of the LTCH Claim

Claim Date(s) of Service
From To

Procedure Code(s) and DRG

Diagnosis Code(s)

REASON FOR SITE NEUTRAL PAYMENT ADJUSTMENT REQUEST

Please select one:

The patient had an immediately preceding inpatient stay at a subsection (d) hospital that is not present in the Medicare claims processing system (such as Veteran Affairs benefit stay.) For a more detailed example, please see Special Edition article, SE 1627.

The patient had an immediately preceding inpatient stay billed to Medicare but the Medicare claim:

 Denied Contained an incorrect discharge date Contained an incorrect number of days that equaled less than 3 ICU/CCU days Was canceled and there is no intention of resubmitting Medicare Other (Please provide a detailed explanation below)

Explanation

SUBMITTER INFORMATION

Name (Please Print)

Signature

Date

Please attach and include:

1. Please complete this form in its entirety.
2. A UB04, Discharge Summary and progress notes from the immediately preceding inpatient stay, and History and Physical.

Please sign and submit this form with all additional documentation to:

Fax:(803) 462-2678

or mail to:

JM MAC - Palmetto GBA, LLC
Part A Medical Review, Mail Code: AG-230
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Columbia, SC 29202-3238