



## Nursing Facility Traumatic Brain Injury (TBI) Notification

Completion of this form is required for notification to the Department to start or discontinue payment to nursing facilities for TBI services. A copy of the physician order sheet identifying the need for TBI services, and the Rancho Los Amigos Cognitive Assessment identifying score Level IV-X, as applicable, for the identified resident must be attached before payment for TBI services will be authorized. Form must be resubmitted as resident advances to another Tier.

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_ City \_\_\_\_\_

Provider Number: \_\_\_\_\_

Resident Name: \_\_\_\_\_

Recipient Identification Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Admit Date: \_\_\_\_\_

Effective Date of TBI Coverage: \_\_\_\_\_ at

- Tier I
- Tier II
- Tier III

- Physician Order Sheet Identifying Need for TBI Services Attached.
- Rancho Los Amigos Cognitive Assessment Identifying Score Level IV-X, As Applicable.

Discontinue TBI Coverage Effective Date: \_\_\_\_\_

Reason TBI Coverage is Discontinued (check one):

- Exceeds Tier Time Limit Prescribed by Rule
- Discharged from Facility
- Died

I certify that all entries on this form are true, accurate, and complete and meet all the requirements of the Illinois Department of Healthcare and Family Services.

\_\_\_\_\_  
Signature of Facility Administrator or Authorized Agent

\_\_\_\_\_  
Date

Send completed document to: Department of Healthcare and Family Services, Bureau of Long Term Care, 201 S. Grand Avenue East, Springfield, Illinois 62763 or fax to 217/524-7114.