State of Illinois
Department of Healthcare and Family Services

REQUEST FOR INAPPROPRIATE LEVEL OF CARE PAYMENT

Date of Notice

through

Billed Dates of Service

Hospital Name

HFS Provider #

Attending Physician

Street Address

National Provider Identification Number

Patient Name

Date of Birth

RE: Recipient ID #

Medical Records #

Services for the client listed above have been rendered in an acute hospital setting due to the unavailability of a long term care facility placement. The following five (5) long term care facilities have been contacted and will not admit this client at this time.

	Facility	Address	Contact Person	Telephone No.
1:				
2:				
3:				
4:				
5:				

Payment for this individual at the statewide exceptional/skilled (circle one) care rate is requested for the above listed service dates (NOTE: PAYMENT WILL NOT BE APPROVED FOR MORE THAN THIRTY-ONE (31) DAYS FOR EACH CLAIM).

Signature
Hospital Authorized Representative

Date

(For Dept Use Only)

A review of the request for inappropriate level of care has been conducted and the following decision rendered:

1. Services from _____ to _____ are not approved.

2. Services provided from _____ to _____ are skilled and hospital based.

3. Services provided from _____ to _____ are exceptional and hospital based.

Both provider representative and/or attending physician may request reconsideration of the decision by submitting a written request within thirty (30) calendar days from receipt of this decision to the Illinois Department of Healthcare and Family Services, Bureau of Long Term Care, Third Floor, 201 South Grand Ave. East, Springfield, Illinois 62763-0002. All reviews will be conducted by the Bureau of Long Term Care. The results of this review will be final.

Signature
HFS Authorized Representative

Date

HFS 3127 (R-3-10)

Print Form