



NC MEDICAID Residential Authorization Form (RAF)

Authorizing Area Program _____
Medicaid Provider # _____

Area Program Designee for Initial Clinical Information _____
Phone # (____) _____

Case Manager at the AP _____
Phone # (____) _____

Child's Name _____ DOB _____
Medicaid ID# _____ Date of Eligibility _____
SS# _____ Gender M F
County of Eligibility _____

Child's Legal Guardian _____
Address _____
Phone # (____) _____

Date of Admission _____ through _____ # Days authorized _____

Level of Residential Care _____ Y Code _____

Transfer within ____ after ____ the initial 120/30 days

Date discharged from previous program _____ # Days authorized _____

Level of Residential Care _____ Y Code _____

Residential Program _____
Address _____
Phone # (____) _____ Medicaid Provider # _____

Contact Person/Title _____

Signature of Authorizing Area Program Representative

ValueOptions will confirm receipt with the Area Program no later than 1 business day from the receipt of this form. If confirmation is not received, please contact 888-510-1150 ext. 6146

ValueOptions Fax (919) 941-0433 **AND** EDS Fax (919) 233-6834

HOW TO COMPLETE THE NC MEDICAID RESIDENTIAL AUTHORIZATION FORM (RAF)

This form must be completed correctly for processing at ValueOptions and EDS

Section 1: Authorizing Area Program

Authorizing Area Program This is the name of the area program that is referring the child to residential placement.

AP Medicaid Provider # This is necessary to insure that the authorization letters are sent to the appropriate referring program.

Area Program Designee for Initial Clinical Information This is the contact person that can give the ValueOptions care manager the clinical details that led to the request for placement.

Phone # This is the number where we can reach the designee between 8 a.m. and 6 p.m.

Case Manager at the AP This is the child's case manager, it may or may not be the same as the designee, but we still need the line filled in either indicating "same as above" or with the specific Case Manager's name.

Phone # This is the number where we can reach the designee between 8 a.m. and 6 p.m.

Section 2: Child

Child's Name The child's full name, if they happen to go by a nickname, we need the legal name first and then the nickname in ().

DOB The child's Date of Birth is necessary to guarantee we are reviewing a recipient who is eligible for this type of service.

Medicaid ID This is the child's Medicaid ID number, it is **absolutely necessary** to have this to process the RAF, if there is an application in process, please note that on this line.

Date of Eligibility We need to verify the child is eligible at the time of service.

SS# The child's Social Security Number.

Gender Please circle which is appropriate, male or female.

County of Eligibility The county in which the child applied for Medicaid.

Child's Legal Guardian We need the name of the Guardian (ie Jane and Jon Doe). If the child is in the custody of DSS, please list the Guardian name/xyz Co. DSS.

Address Full street address (include lot#, apt.#, etc.), city, state, zip. Please do not assume that ValueOptions has a listing of DSS sites to refer to.

Phone# This is the number where we can get in touch with the guardian if there are any concerns about treatment, etc.

Section 3: Admission

Date of Admission This is the day the child actually walked through the doors of the residential facility, not the date the child is expected to be admitted and not the date the home became independently enrolled.

Through This date should be the 120th day or the last day the AP has authorized services (if the AP is only authorizing 30 days at a time, this date will change monthly, but the admit date will stay the same.)

Days authorized Either 30, 120, 90, 60 etc. (if you are sending this in on a transfer and VO has already been reviewing for medical necessity, please put "0" in this spot as the AP is not at liberty to authorize additional days unless the child has been discharged to HOME for 15 days or more. If this is a transfer within the 120/30 days please indicate the # days remaining in the initial 120/30 period that you are authorizing)

Level of Residential Care This is either II, III, or IV. Do not use this form for precertification of PRTF.

Y Code The specific code that agrees with the level of treatment and # beds. (Y2363, Y2348, Y2349, Y2360, Y2361)

Transfer within/after If the child is transferring from another program/home, please check whether it is "within" the 120/30 days or "after" the 120/30 days.

Date discharged from previous program This is the last day the child was in the home immediately preceding the transfer.

Days authorized Either 30, 120, 90, 60 etc. (if you are sending this in on a transfer and VO has already been reviewing for medical necessity, please put "0" in this spot as the AP is not at liberty to authorize additional days unless the child has been discharged to HOME for 15 days or more. If this is a transfer within the 120/30 days please indicate the # days remaining in the initial 120/30 period that you are authorizing)

Level of Residential Care This is either II, III, or IV. Do not use this form for precertification of PRTF.

Y Code The specific code that agrees with the level of treatment and # beds. (Y2363, Y2348, Y2349, Y2360, Y2361)

Section 4: Residential Program

Residential Program The name of the Group Home and not the Billing Agency should be shown here.

Address This should be the full address of the Group Home.

Phone # of the contact person/reviewer with the Group Home.

Medicaid Provider # of the Group Home. Do not use the Area Programs

Medicaid Provider#.

Contact Person/Title the person who will review with VO.

Signature This form should be signed by the person authorizing placement with the Area Program.

Once completed, the RAF must be faxed to both ValueOptions, as notification of placement and to EDS for Claims payment.

This form must be completed correctly for processing at ValueOptions and EDS.