Government of the District of Columbia
Department of Health Care Finance

Out-of-State Nursing Facility Placement

BENEFICIARY					
Date:	Last Name: First: M.I.:	Medicaid ID:	Medicare ID:	Gender: ❑ M ❑ F	
SSN:	Permanent street address:	City:	ST:	ZIP:	Phone:
Reason(s) placement requested:					
Diagnosis:					
Prognosis:					

REQUIRED TREATMENT AND FREQUENCY■				
	Daily	Weekly	Bi-weekly	Monthly
Behavioral Modification	❑	❑	❑	❑
Occupational Therapy	❑	❑	❑	❑
Physical Therapy	❑	❑	❑	❑
Respiratory Care	❑	❑	❑	❑
Speech/Hearing	❑	❑	❑	❑

■*Check all that apply*

Upload this form via the Qualis Health Provider Portal at www.qualishealth.org. In the Healthcare Professional Drop-Down Menu select DC Medicaid-> Provider Resources-> Qualis Health Provider Portal. You may obtain assistance in registering for the Qualis Health Provider Portal by contacting providerportalhelp@qualishealth.org

Revised September 11, 2019