HealthPlan OF SAN MATEO
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Health Plan of San Mateo
Please type into all fields and Fax this form to:
(650) 829-2079

Medi-Cal Managed Care Plan (MCP) Intermediate Care Facility/Home for the Developmentally Disabled (ICF/DD) Authorization Request

1. Member Last Name* First Name* MI

2. Member ID* Member DOB* MM-DD-YYYY

3. Facility/Home Name* Facility NPI* Phone* Fax*

4. Facility Street Address* City* State* ZIP*

5. Contact Name Contact Phone

6. Primary ICD Diagnosis Code*

7. Initial ☐ Transfer ☐ Re-admission ☐ Reauthorization ☐ (check only one) *

8. Prescribing Physician Name Physician NPI

9. Level of Care Requested* ICF/DD ☐ ICF/DD-H ☐ ICF/DD-N ☐ (check one box)* ⇒ ☐ Leave of Absence ☐ All Inclusive Room and Board (check one box)*

10. Admit Date* MM-DD-YYYY From Date* MM-DD-YYYY Through Date* MM-DD-YYYY

11. CPT / HCPS Code* Modifier Services Requested Units*

12. Physician Signature* Date* MM-DD-YYYY

Explanation of Form Items

1. **Member Name.** Enter the Member's full name from the Benefits Identification Card (BIC).
2. **Medi-Cal Identification Number and Eligibility.** When entering the recipient identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. Do not enter any characters (dashes, hyphens, special characters, etc.) in the remaining blank positions of the Medi-Cal ID field. The county code and aid code must be entered just above the recipient Medi-Cal Identification Number box.
3. **Facility/Home Address and Contact Information.** Enter the facility/home's physical address and the name, email, and telephone contact information for the individual submitting the request.
4. **ICD Diagnosis Codes**. List the primary ICD diagnosis code for the Member.
5. **New, Transfer, or Readmission Authorization**. Note if the authorization is for a new Member, a transfer to another ICF/DD Facility/Home, or for a readmission.
6. **Prescribing Physician Name and License Number**. Enter the full name and license number for the physician authorizing the service from the Facility/Home. The state license number is the Medi-Cal rendering provider number.
7. Enter **Level of Care** — ICF-DD, ICF/DD-H, or ICF/DD-N, as defined below:

   Intermediate Care Facility/Home for the Developmentally Disabled (ICF/DD, ICF/DD-H, and ICF/DD-N). These three models are offered, as appropriate, to individuals with intellectual and developmental disabilities (IDD) who are eligible for Regional Center services as administered by the Department of Developmental Services. The models offer specialized living arrangements and are briefly defined as follows:

   - **ICF/DD** (Developmentally Disabled): "Intermediate care facility/home / developmentally disabled" is a facility/home (up to over 60 beds) that offers 24-hour personal care, habilitation, developmental, and supportive health services for individuals with IDD whose primary need is for develop mental services and who have a recurring but intermittent need for skilled nursing services.
   - **ICF/DD-H** (Habilitative): "Intermediate care facility/home / developmentally disabled habilitative" is a home with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services for 15 or fewer individuals with IDD who have intermittent recurring needs for nursing services, but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care.
   - **ICF/DD-N** (Nursing): "Intermediate care facility/home / developmentally disabled nursing" is a home with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for individuals with IDD who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated.

8. **Admit Date This Service**. Enter the recipient's admission date to the facility/home in MM-DD-YYYY format (for example, June 12, 2024 = 06-12-2024).
9. **Period Of Care Requested.** Enter the "From Date" and the "Through Date" requested for authorization in MM-DD-YYYY format (for example, June 12, 2024 = 06-12-2024).
10. **Physician Signature**. The authorization request must be initiated by the ICF/DD Facility/Home. Per 22 CCR section 51343(a), the ICF/DD Facility/Home's attending physician must sign the authorization request and certify to the MCP that the Member requires this level of care. ICF/DD Facility/Homes may submit the physician's signature through fax, scanning, or uploading as an attachment.