DRAFT
100% FMAP
Care Coordination Documentation
(IHS/Tribal Facility Name Here)

Date of service: _____

Patient name: _____ **Medicaid/OHP ID # (Prime):**_____

Patient DOB:_____

Covered Facility Name: _____

Services Provided (check all that apply):

- ▫ Hospitalization
- ▫ Emergency Department
- ▫ Imaging
- ▫ Lab
- ▫ Other _____

Care Coordination (check all that apply):

- ▫ IHS/Tribal facility responsible for patient's ongoing care
- ▫ IHS/Tribe requested service
- ▫ Patient self-referral (e.g. emergency care)
- ▫ Covered facility transmitted relevant information back to IHS/Tribal facility and information incorporated into patient record.

_____

Person Completing Form

_____

Date