Optum

OES 1000 Form

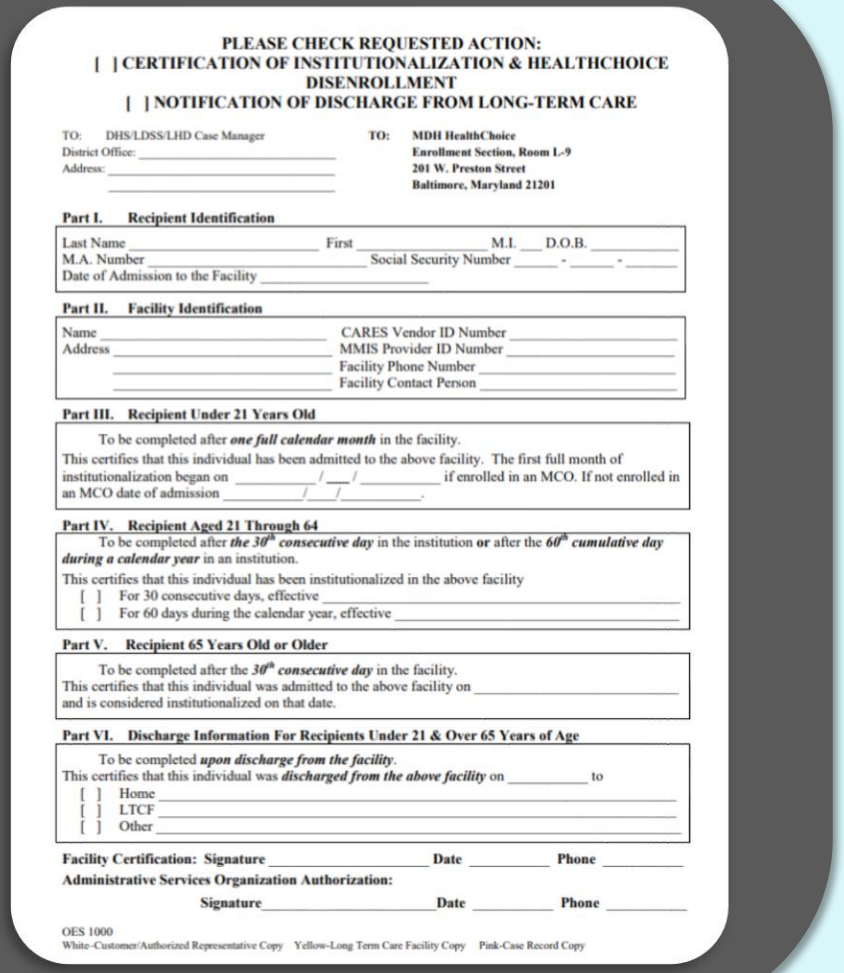
Optum Maryland Provider Training

Participant Guide

OES 1000

OES 1000 (Office of Eligibility Services Form)

1. Complete **Part I and II** for all Medical Assistance recipients admitted to your facility.
2. Follow the instructions in **Part III, IV and V** to determine when to complete and submit this form for each recipient.
3. The facility's authorized representative must sign and date the form.
4. Submit the entire, completed, signed form to the Administrative Services Organization (ASO) for their signature.
5. When the ASO returns the signed form to you:
   - Send the copy to the DHMH HealthChoice Enrollment Section.



PLEASE CHECK REQUESTED ACTION:
[ ] CERTIFICATION OF INSTITUTIONALIZATION & HEALTHCHOICE DISENROLLMENT
[ ] NOTIFICATION OF DISCHARGE FROM LONG-TERM CARE

TO: DHS/LDSS/LHD Case Manager
District Office: _____
Address: _____

TO: **MDH HealthChoice**
Enrollment Section, Room L-9
201 W. Preston Street
Baltimore, Maryland 21201

Part I. Recipient Identification
Last Name _____ First _____ M.I. ___ D.O.B. _____
M.A. Number _____ Social Security Number ____ - ____ - ____
Date of Admission to the Facility _____

Part II. Facility Identification
Name _____ CARES Vendor ID Number _____
Address _____ MMIS Provider ID Number _____
_____ Facility Phone Number _____
_____ Facility Contact Person _____

Part III. Recipient Under 21 Years Old
To be completed after ***one full calendar month*** in the facility.
This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on ____/___/____ if enrolled in an MCO. If not enrolled in an MCO date of admission ____/___/____.

Part IV. Recipient Aged 21 Through 64
To be completed after ***the 30th consecutive day*** in the institution **or** after the ***60th cumulative day during a calendar year*** in an institution.
This certifies that this individual has been institutionalized in the above facility
[ ] For 30 consecutive days, effective _____
[ ] For 60 days during the calendar year, effective _____

Part V. Recipient 65 Years Old or Older
To be completed after the ***30th consecutive day*** in the facility.
This certifies that this individual was admitted to the above facility on _____ and is considered institutionalized on that date.

Part VI. Discharge Information For Recipients Under 21 & Over 65 Years of Age
To be completed ***upon discharge from the facility***.
This certifies that this individual was ***discharged from the above facility*** on _____ to
[ ] Home _____
[ ] LTCF _____
[ ] Other _____

Facility Certification: Signature _____ **Date** _____ **Phone** _____
Administrative Services Organization Authorization:
Signature _____ **Date** _____ **Phone** _____

OES 1000
White–Customer/Authorized Representative Copy Yellow–Long Term Care Facility Copy Pink–Case Record Copy

Part III

Part III. Recipient Under 21 Years Old

To be completed after ***one full calendar month*** in the facility.

This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on _____ / ___ / _____ if enrolled in an MCO. If not enrolled in an MCO date of admission _____/____/_____.

Check if the recipient is enrolled in an MCO.

- EVS will indicate if they are enrolled in an MCO (shown below).

recipient eligibility verification

Step 2 of 2 — Please print this page for your records. For questions please contact Provider Relations at: 410-767-5503 or 800-445-1159

1/6/2023 6:25:21 AM — Reference number: [redacted]

Inquiring provider: [redacted]

RECIPIENT INFORMATION

MA number: — SSN:

Recipient name:

ELIGIBILITY INFORMATION

For 1/5/2023 12:00:00 AM — **ELIGIBLE for date of service**

Recipient's Re-Determination Date is not available at this time.

Citizenship verified

Identity verified

OHR/FIA form **9709S** must be completed if long term care services are required

BENEFIT DESCRIPTION

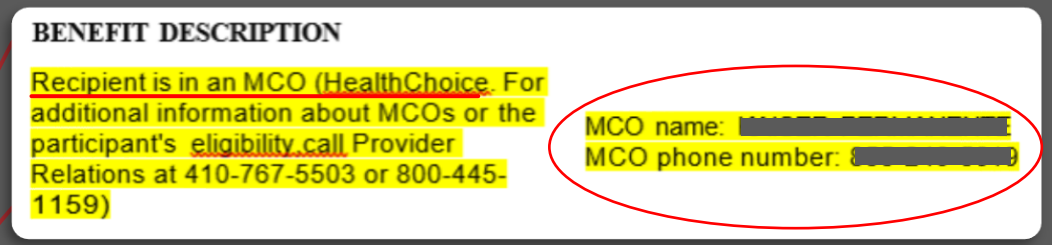
Recipient is in an MCO (HealthChoice. For additional information about MCOs or the participant's eligibility.call Provider Relations at 410-767-5503 or 800-445-1159)

MCO name: [redacted]
MCO phone number: [redacted]

BENEFIT EXCLUSIONS

BENEFIT LIMITATIONS

OTHER PAYORS



BENEFIT DESCRIPTION

Recipient is in an MCO (HealthChoice. For additional information about MCOs or the participant's eligibility.call Provider Relations at 410-767-5503 or 800-445-1159)

MCO name: [redacted]
MCO phone number: [redacted]

- When you review the recipient eligibility verification, you can find the MCO information under the 'benefit description' section.

Part III

Part III. Recipient Under 21 Years Old

To be completed after ***one full calendar month*** in the facility.

This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on _____/___/_____ if enrolled in an MCO. If not enrolled in an MCO date of admission _____/____/_____.

Psychiatric Hospitals: Input the **first day** of the ***next*** calendar month in the shaded orange area shown above.

- For Example: If they were admitted on 5/14/23 you would input 6/1/23 on the form.
- The form should not be sent to Optum until 7/1/23.

Residential Treatment Care (RTC): If **enrolled in an MCO** input the first day of the ***next*** calendar month in the shaded orange area shown above.

- For Example: If they were admitted on 5/14/23 you would input 6/1/23 on the form.
- The form should not be sent to Optum until 7/1/23.

Optum

Part III

Part III. Recipient Under 21 Years Old

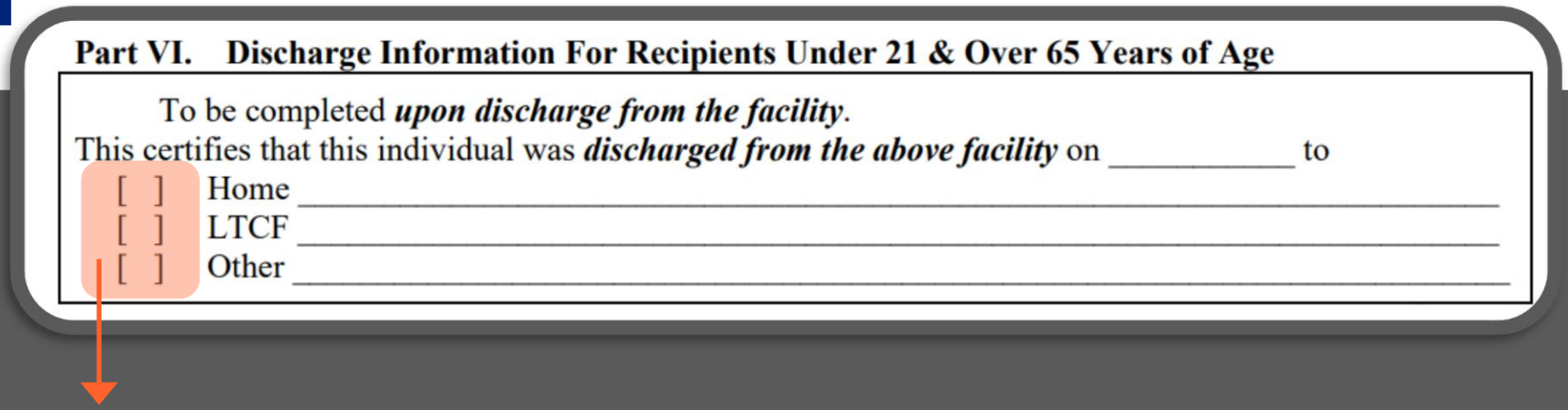
To be completed after ***one full calendar month*** in the facility.

This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on _____ / ___ / _____ if enrolled in an MCO. If not enrolled in an MCO date of admission _____/____/_____.

Residential Treatment Care: If they are **NOT** enrolled in an MCO upon admission the admit date must be the date you are requesting for.

- For Example: If they were admitted on 5/14/23 then the admission date would be 5/14/23. Place that date in the orange area shown above.

Part VI



Part VI. Discharge Information For Recipients Under 21 & Over 65 Years of Age

To be completed ***upon discharge from the facility***.
This certifies that this individual was ***discharged from the above facility*** on _____ to

[ ] Home _____
[ ] LTCF _____
[ ] Other _____

Please check the box on where the recipient is discharging to.

Home: Please record the home's address.

LTCF (Long Term Care Facility): Please write the name of the facility they are going to.

Other: Please note down the exact specifics.

Have the appropriate individuals sign in this section below.

Facility Certification: Signature _____ **Date** _____ **Phone** _____

Administrative Services Organization Authorization:

Signature _____ **Date** _____ **Phone** _____

LTC/OES Process

A. Send the OES 1000 to Optum for authorization and signature.

B. Send the signed OES 1000 form and application to:

MA Waiver Unit,
6 St Paul Street, Room 400
Baltimore, MD 21202

C. Send a copy of the OES 1000 form to:

MDH Healthchoice
Enrollment Section, Room L-9
201 Preston Street
Baltimore, MD 21201

D. Please keep a copy of the document at the facility for the child's case file.

- *The MDH Waiver unit has 45 days from receipt to process the LTC App & OES.*
- *The MDH Waiver unit can only retro LTC back 3 months from the date of receipt of the properly completed LTC Application and OES 1000 forms.*
- *It is very important to follow the required timelines as no backdating past these time frames will be permitted.*