Optum

OES 1000 Form

Optum Maryland Provider Training



Participant Guide



OES 1000 (Office of Eligibility Services Form)

- 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.



- 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.

Part I. Recipient Identification Last Name	TO: DHS/LDSS/LHD Case Manager District Office:	TO: MDH HealthChoice Earollment Section, Room L-9 201 W, Preston Street Baltimore, Maryland 21201
Last Name First M.ID.O.B. M.A. Number	Part I. Recipient Identification	
Part II. Facility Identification Name	Last Name M.A. Number Date of Admission to the Facility	First M.I D.O.B Social Security Number
Name CARES Vendor ID Number Address MMIS Provider ID Number	Part II Facility Identification	
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//	NameAddress	CARES Vendor ID Number MMIS Provider ID Number Facility Phone Number Facility Contact Person
To be completed after <i>one full calendar month</i> in the facility. This certifies that this individual has been admitted to the above facility. The first full month of institutionalization began on//	Part III. Recipient Under 21 Years	Old
Part V. Recipient 65 Years Old or Older To be completed after the 30 th consecutive day in the facility. This certifies that this individual was admitted to the above facility on	This certifies that this individual has b institutionalization began on an MCO date of admission Part IV Recipient Aged 21 Through	een admitted to the above facility. The first full month of if enrolled in an MCO. If not enrolled ir
To be completed after the 30 th consecutive day in the facility. This certifies that this individual was admitted to the above facility on	This certifies that this individual has b institutionalization began on an MCO date of admission Part IV. Recipient Aged 21 Throug To be completed after the 3d ⁶ c during a calendar year in an institutio This certifies that this individual has b [] For 60 days during the calence [] For 60 days during the calence	een admitted to the above facility. The first full month of if enrolled in an MCO. If not enrolled in end end end end end end end end
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	This certifies that this individual has b institutionalization began on an MCO date of admission Part IV. Recipient Aged 21 Throug To be completed after the 3d ⁶ during a calendar year in an institutio This certifies that this individual has b [] For 60 days during the calence Part V. Recipient 65 Years Old or	een admitted to the above facility. The first full month of if enrolled in an MCO. If not enrolled in
To be completed upon discharge from the facility. This certifies that this individual was discharged from the above facility on to [] Home[] LTCF	This certifies that this individual has be institutionalization began on an MCO date of admission Part IV. Recipient Aged 21 Throug To be completed after the 30 th of during a calendar year in an institutio This certifies that this individual has be [] For 30 consecutive days, effic [] For 60 days during the calene Part V. Recipient 65 Years Old or To be completed after the 30 th or This certifies that this individual was a and is considered institutionalized on t	een admitted to the above facility. The first full month ofi f enrolled in an MCO. If not enrolled iri f enrolled in an MCO. If not enrolled iri f each matched for the form of a fler the form cumulative day n. een institutionalized in the above facility eetivedat year, effectivedat year, effectiveoDderoDderonsecutive day in the facility. dmitted to the above facility on
Facility Certification: Signature Date Phone Administrative Services Organization Authorization:	This certifies that this individual has be institutionalization began on an MCO date of admission Part IV. Recipient Aged 21 Throug To be completed after the 30 th of during a calendar year in an institutio This certifies that this individual has be [] For 30 consecutive days, effor [] For 60 days during the calene Part V. Recipient 65 Years Old or To be completed after the 30 th or This certifies that this individual was a and is considered institutionalized on t Part VI. Discharge Information Fe	een admitted to the above facility. The first full month ofi f enrolled in an MCO. If not enrolled iri f enrolled in an MCO. If not enrolled iri f each matched for the form and the enrolled iri f each matched for the form and the enrolled in the above facility enrolled for the each matched form and the enrolled form and the each matched form and the enrolled form and the each matched form and the each m
Administrative Services Organization Authorization:	This certifies that this individual has be institutionalization began on an MCO date of admission Part IV. Recipient Aged 21 Throug To be completed after <i>the 30th of</i> <i>during a calendar year</i> in an institution This certifies that this individual has be [] For 30 consecutive days, effi [] For 60 days during the calend Part V. Recipient 65 Years Old or To be completed after the <i>30th of</i> this certifies that this individual was a and is considered institutionalized on t Part VI. Discharge Information Fe To be completed <i>upon discharg</i> This certifies that this individual was a [] Home [] LTCF [] Other	een admitted to the above facility. The first full month of
	This certifics that this individual has be institutionalization began on an MCO date of admission Part IV. Recipient Aged 21 Throug To be completed after <i>the 3dth of</i> <i>during a calendar year</i> in an institution This certifies that this individual has be [] For 30 consecutive days, effi [] For 60 days during the calend Part V. Recipient 65 Years Old or To be completed after the <i>3dth of</i> this certifies that this individual was a and is considered institutionalized on t Part VI. Discharge Information Fe To be completed <i>upon discharg</i> This certifies that this individual was a [] Home [] LTCF [] Other Facility Certification: Signature	een admitted to the above facility. The first full month of

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).

RAPE.		You are currently signed in as	
	recipient eligit	bility verification	
Step 2 of 2	Please print this page for your records. For <u>guestions</u> please contact Provider Relation	ons at. 410-767-5503 or 800-445-1159	1
	1/6/2023 6:25:21 AM	Reference number	
	Inquiring provider:		
	RECIPIENT INFORMATION		
	MA number:	SSN:	
	Recipient name:		
	FI ICIDII ITY INFORMATION		
	For 1/5/2023 12:00:00 AM	ELIGIBLE for date of service	
	Recipient's Re-Determination Date is not a	available at this time	
	Citizenship verified	ALL	- 88
	Identity verified		- 10
	OHR/FIA form 9709S must be completed	I if long term care services are required	
(
	Recipient is in an MCO (<u>HealthChoice</u> For additional information about MCOs or the participant's <u>eligibility call</u> Provider Relations at 410-767-5503 or 800-445- 1159)	MCO name.	I
	BENEFIT EXCLUSIONS		
	BENEFIT LIMITATIONS		
	OTHER PAVORS		



• 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.



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

P	art VI	. Disc	harge Information For Recipients Under 21 & Over 65 Years of Age	
Т	To his cer	o be con	npleted <i>upon discharge from the facility</i> . at this individual was <i>discharged from the above facility</i> on	to
		Home		
	[]	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.



Changes to business policies and procedures may cause the information provided here to become out-of-date. Always refer to the policy and procedure documentation provided to you within your business unit and/or consult with your manager or team lead if you have any questions and to validate sources of truth.

Optum is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are the property of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

© 2023 Optum, Inc. All rights reserved.