Meal and Lodging Authorization Form

Today's Date: _____

Patient Name and Subscriber ID: _____ D.O.B: _____

Type of Insurance: _____

Parent (Guardian/Escort) Name: _____ Phone Number: _____

REQUESTING FACILITY CONTACT INFO:

Medical Facility: _____ Name (Title): _____

Facility Phone: _____ Facility Fax: _____ Email: _____

DIAGNOSIS: _____

PLANNED TREATMENT: _____

***Clinical information is required to support the need for Meals and Lodging reimbursement for United Healthcare members.*
***Attach completed ModivCare (formerly Logisticare) Michigan Non-Emergency Transportation Services Medical Necessity Form for Medicaid beneficiaries in Wayne, Oakland and Macomb counties*

Service Requested with Dates of Service (e.g., Meals, Lodging): _____

Is Transportation Requested (vehicle pickup, gas reimbursement – If so, dates needed)? _____

Hotel Name (Phone/Fax Number): _____

MEDICAID RATES:
Lodging: (one caregiver or guardian of child only) ……. $75.00 per day maximum
Meals: Inpatient (one caregiver or guardian of child only) …….. $8.50 breakfast | $8.50 lunch | $19.00 dinner

Hospital Facility Meal & Lodging Reimbursement
Meals: (member and/or one caregiver) .....$19.00 per diem each
Lodging: (member and/or one caregiver) .....$75.00 per day maximum

***Note:** If suggested donation amount to the general public is lower than $75.00 per day, Medicaid will reimburse at the lower, general public rate.*

Determination: _____

Date received request from facility: _____

ModivCare manager: _____ ModivCare facility representative: _____

BILLING INFORMATION:
ModivCare
Attn: MI Exceptions Manager
26877 Northwestern Highway Suite 211
Southfield, MI 48033 Exceptions Dept. Phone: (866) 569-1908 | Dept. Fax: (866) 569-1910 | Dept. Email: MIExceptions@modivcare.com

*****A detailed invoice is requested within 30 days of service to ensure timely processing of payment*****