ATTACHMENT VI

MINNESOTA DEPARTMENT OF HEALTH
Case Mix Review
85 East Seventh Place, Suite 300
P.O.Box 64938
St. Paul, MN 55164-0938

REQUEST FOR RECONSIDERATION OF RESIDENT CLASSIFICATION

NOTE: Facilities making a request must provide notice of such request to the resident on the same date the request is submitted to the department and provide a copy of that notice with this reconsideration request See FACILITY MANUAL FOR COMPLETING CASE MIX REQUESTS FOR CLASSIFICATION, Section VIII.

Send this form along with documentation to support a requested classification reconsideration. **The request and documentation must be submitted within 30 days of the receipt of the notice of classification.**

Please provide the following information:

RESIDENT'S NAME_____ CMR ID NUMBER_____

FACILITY NAME_____ FACILITY PHONE # (___)_____

FACILITY ADDRESS _____ LOCATION NUMBER _____

*Date the FACILITY received the classification notice:		*To be completed for FACILITY initiated request only
*Date the FACILITY distributed the notices:		
Date the resident/representative received the notice:		
Date the resident/representative requested documentation:		
Date the FACILITY provided documentation to the resident/representative:		

In order for the Department to establish a basis for reconsidering the classification:

- Enclose a copy of the resident's assessment form. The FACILITY must provide a copy of the assessment and documentation to the resident/representative within three (3) working days of written request, AND
- Attach documentation from the medical record supporting your reasons for disagreement with the classification. The documentation must be dated on or prior to the date the assessment was completed. **Note RN Signature Date on the assessment form**, AND
- All areas of this form must be completed as indicated. On the reverse: Write a **brief** description of the basis for your disagreement with the case mix classification.

REQUEST SUBMITTED BY:

" AUTHORIZED REPRESENTATIVE OF THE FACILITY
" RESIDENT
" RESIDENT'S AUTHORIZED REPRESENTATIVE

I signify by my signature that these statements are correct and factual to the best of my knowledge

SIGNATURE _____ DATE_____