pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

LONG-TERM CARE PRIOR ROOM & BOARD MEDICAL EXPENSE (PME) REQUEST FORM

PLEASE COMPLETE ALL FIELDS BELOW AND RETURN TO YOUR REGION'S FIELD OPERATIONS TEAM FINANCIAL REPRESENTATIVE.

1. REQUEST DATE	
2. NURSING FACILITY NAME	
3. NURSING FACILITY SERVICE PROVIDER ID NUMBER	
4. RESIDENT NAME	
5. DATE OF ADMISSION	
6. PRIOR PAYOR SOURCES	
7. MEDICAL ASSISTANCE (MA) APPLICATION DATE	
8. DATE MA APPLICATION SIGNED	
9. MA EFFECTIVE DATE	
10. RECIPIENT IDENTIFICATION NUMBER (RID)	
11. COUNTY RECORD NUMBER	
12. CASEWORKER'S NAME	
13. TOTAL AMOUNT OF PRIOR ROOM & BOARD MEDICAL EXPENSE	
14. TOTAL AMOUNT OF PRIOR ROOM & BOARD MEDICAL EXPENSE REQUESTED TO BE TAKEN AS OME **(MEDICALLY NECESSARY EXPENSES ONLY – BILLED AS CODE 34 IN PROMISE)**	
15. TOTAL PAYMENTS RECEIVED TO DATE	
16. TOTAL BALANCE REMAINING	
17. EXPLAIN HOW AND WHEN THE PRIOR ROOM & BOARD MEDICAL EXPENSE OCCURRED. INCLUDE ALL COMMUNICATION WITH THE CAO BOTH WRITTEN AND VERBAL, ALONG WITH A DETAILED COPY OF THE RESIDENT'S BILLING.	

BY SIGNING BELOW, I CERTIFY the facility has not claimed any of these expenses as bad debt, has not billed any other payor sources, including PA's Medical Assistance program, etc. and that expenses claimed were incurred within 6-months of the MA application date.

_____ _____ _____

NF REPRESENTATIVE/DESIGNEE **TITLE** **DATE**

AS OF THE DATE BELOW, THIS PRIOR ROOM & BOARD REQUEST HAS BEEN Choose an item.

_____ _____

FINANCIAL REPRESENTATIVE SIGNATURE **DATE**

UPDATED 02/02/2022