PLEASE PRINT

Ohio Department of Health

Medical Application

Bureau for Children With Medical Handicaps, 246 North High Street, P.O. Box 1603, Columbus, Ohio 43216-1603

☐ Diagnostic ☐ Treatment ☐ Case Renewal ☐ Service Coordination ☐ PHN Referral ☐ Adult Hemophilia

⁎1. Child's/Client's name (last, first, mi)				2. Case number (child's/client's)	
⁎3. Address				⁎4. County	
City		⁎State	⁎ZIP	Health department code	
⁎5. Child's/Client's birthdate	⁎6. Social Security number (child's/client's)	⁎7. Sex ☐ 1. Male ☐ 2. Female	⁎8. Ethnic group	9. Ohio resident ☐ 1. Yes ☐ 2. No	
⁎10. Parent's/Legal guardian's/Client's name (last, first)		⁎15. Parent's/Legal guardian's/Client's name (last, first)			
⁎11. Address		⁎16. Address			
⁎City	⁎State ⁎ZIP	⁎City		⁎State ⁎ZIP	
12. Social Security number		17. Social Security number			
⁎13. Home phone ( )	⁎14. Work phone ( )	⁎18. Home phone ( )		⁎19. Work phone ( )	

Insurance Information

FOR BCMH USE ONLY

⁎20. Health insurance coverage ☐ 1. Yes ☐ 2. No	Policy number	Begin date	End date	Carrier number
Health insurance company name		Name of insured		
⁎21. Health insurance coverage ☐ 1. Yes ☐ 2. No	Policy number	Begin date	End date	Carrier number
Health insurance company name		Name of insured		
22. Dental insurance coverage ☐ 1. Yes ☐ 2. No	Carrier number	Begin date	End date	
Dental insurance company name		Name of insured		
23. Vision care insurance coverage ☐ 1. Yes ☐ 2. No	Carrier number	Begin date	End date	
Vision care insurance company name		Name of insured		

⁎24. Medicaid eligible ☐ 1. Yes ☐ 2. No	⁎Medicaid recipient/Billing number	Begin date	End date	25. S.S.I. eligible ☐ 1. Yes ☐ 2. No

⁎26. Managing physician's/Service coordinator's name			Site ☐ Private office ☐ Clinic
⁎27. Address			28. Telephone number ( )
⁎City	⁎State ⁎ZIP		⁎29. Provider number
⁎30. Primary diagnosis	⁎I.C.D. code	⁎31. Secondary diagnosis	⁎I.C.D. code
⁎32. Tertiary diagnosis	⁎I.C.D. code	⁎33. Quaternary diagnosis	⁎I.C.D. code

⁎**DATA REQUIRED IN ORDER TO PROCESS**

Child's/Client's name	Case number

34. If child/client has any other handicapping condition(s), please describe

35. Name of primary care physician	36. Name of primary care dentist

37. Major Services

Category of service	Name and address of provider	Provider number	Unit of service	Source of payments

38. Recommendations (Include/attach Plan of Treatment, Medical Report and/or Discharge Summary.)

*39. Managing physician's/Service coordinator's signature	*Date	*40. Initial date of exam

*Print physician's name

41. Name of person completing form	Telephone ( )	*42. Most recent date of exam

Public Health Nurse Referral

43. Name	44. Health department	45. Telephone ( )

46. Reason	Date of scheduled exam

I hereby authorize the managing physician or service coordinator listed above to submit this application to the Ohio Department of Health, Bureau for Children with Medical Handicaps (hereinafter referred to as "BCMH"), for services for the child/client (hereinafter referred to as "client") named on the front of this application. I authorize BCMH to release confidential information concerning the client's medical condition and treatment, any and all financial information and third-party coverage to county and/or city health departments located in the city or county where the client lives or receives treatment and to health care and service providers, facilities and third-party payors (and their agents and employees) for the purposes of providing or facilitating the delivery of or arranging for services to the client. This authorization includes the release of any and all information concerning the client's medical conditions and treatment, including if applicable, the client's HIV testing or diagnosis of AIDS or AIDS-related conditions.

I certify and attest that all the information given by me on this form and other BCMH application forms is true and accurate. I hereby give my permission to have all financial information verified. I authorize the release to BCMH of any and all information pertaining to my contract of insurance as to claims filed on behalf of client and amounts paid and to whom these claims or amounts were paid.

This release authorization is effective from the date of my signature and will remain in effect until such time as I expressly revoke it in writing. I understand that the above-referenced information will not be released to any other entity without an additional written release authorization from me or other person having legal authority to provide such release or as required by law.

I have read this authorization to release information and fully understand its contents.

*47. Parent's/Guardian's/Client's signature	*Date

*Print name	*Relationship to child/client

48. Approved ☐ 1. Yes ☐ 2. No	49. Program	Code	50. Effective date	51. Expiration date

52. Denial reason	Code	53. Denial reason	Code

54. Nurse case manager	Date

***DATA REQUIRED IN ORDER TO PROCESS**

Completion of Medical Application Form (MAF) HEA 7115

Information required for processing is marked with an asterisk (*). MAF's that are incomplete or illegible will be returned to the sender.

Front of MAF:

- Check appropriate box at top of form (diagnostic, treatment, case renewal, service coordination, PHN referral, adult hemophilia, HMG/Help Me Grow pilot). A separate MAF is required for each program requested.
- If the child/client has a sibling who is currently on the BCMH program or has recently been on the program, indicate sibling's name, case number, or date of birth at the top of the MAF.
- Complete all demographic information and identifying information about the child/client and family (boxes 1–19).
- Complete "insurance information" section (boxes 20-25). Information on the primary health insurance for the client, Medicaid status and Medicaid recipient number is required.
- Identify the physician/service coordinator by first and last name (box 26), site of the visit, address (box 27), telephone number (box 28) and BCMH provider number (box 29).
- Fill in eligible diagnoses and ICD code numbers (box 30-35).

Back of MAF:

- Fill in child/client's name and case number, if known.
- Provide information about other handicapping conditions (box 34).
- Fill in the name of the child/client's primary care physician (box 35) and primary care dentist (box 36).
- In box 37, list major services needed and the provider for each service (i.e., "surgery/special procedure: name of surgeon and name of facility; in-patient hospital stay: name of hospital). All services must be provided by a BCMH provider. However, in many cases the name of the provider is not required on the MAF. This would include services such as therapy services, eye glasses, hearing aids and medical supplies.
- A medical report, plan of treatment and/or a discharge summary should be attached to the MAF.
- The managing physician must sign and date the form and print his/her name (box 39). If the MAF is an application for service coordination, the service coordinator must sign and date the form.
- The initial date of exam (box 40) and the most recent date of exam (box 42) are necessary to establish the effective dates for BCMH services and are, therefore, required data.
- The name of the person completing the form should be entered in box 41. This is helpful should there be questions regarding the MAF.
- If the MAF is a PHN Diagnostic Referral, boxes 43–46 must be completed by the PHN.
- The parent, guardian or client, if over 18 years of age, must sign and date the form and complete other information requested in box 47. BCMH cannot process the MAF if the Release and Consent statement is not signed.
- BCMH requires the signature of a client who is the legal age of 18 years of older, unless the client is not medically able to sign, in which case a notation as to why the client is unable to sign should be made.