NC D l . Physician‟s Signature for author‟zation of level of care

This form is to verify that I have provided the information submitted on the State Approved Level Of Care Form on the NCTracks website on behalf of the recipient. I have assessed the following level of care to be appropriate for this individual:

NF____ NF Rehab____ Vent____ Specialty Hospital Rehab ____ Extended Care _____

CAP/DA Intermediate_____ CAP/DA Skilled____

CAP/C Skilled _____ CAP/C Hospital PACE _____

Recipient Information:

Name:_____ Recipient ID:_____

Receiving Facility Name (if known):_____

Date LOC/ determination made: _____

Date of Move to facility (if known)_____

I verify that the information on the state approved level of care form is accurate and reflects the needs of the recipient regarding the above named individual.

_____ _____

MD Signature Date signed

Fax this form to b / ¢ℕl·Ŏ]ă at: (855ú 710-1964