471-000-73 Instructions for Completing Form MS-6, "Ambulatory Room and Board Agreement"

USE: Form MS-6, "Ambulatory Room and Board Agreement," is required for enrollment of hospitals as providers of Medicaid ambulatory room and board services under 471 NAC 10-005.26.

COMPLETION: Form MS-6 must be completed in entirety by an authorized representative of a Medicaid enrolled hospital as follows:

Note: Attach separate pages to continue responses, if necessary.

NAME OF HOSPITAL FACILITY: Enter the name of the hospital provider.

DATE: Enter the current month, day, and year.

ADDRESS: Enter the hospital provider's complete street address.

MEDICAID PROVIDER NUMBER: Enter the hospital's Nebraska Medicaid 11-digit Provider ID Number.

CITY, STATE, ZIP CODE: Enter the hospital provider's city, state, and zip code.

DESCRIPTION: Enter a complete narrative description of the ambulatory room and board facility including: the physical location of the facility, the street address if different from the hospital provider's address, the distance from the hospital building, arrangements for transportation if the facility is not located on the hospital campus, number of beds available, type of facility (hospital rooms, apartments, house with bedrooms, shared bathroom/kitchen services), etc.

SERVICES AVAILABLE: List the services available to clients in ambulatory room and board such as: meals, lodging, laundry service, kitchen facilities, shower, nursing services, non-nursing services.

CHARGES: Enter the charge to the Department for one day of lodging, meals, and meals and lodging for a client only, an attendant only, and a client and an attendant.

CONTACT PERSON: Enter the name of a person (or department) that can be contacted to arrange ambulatory room and board services. Include the person's title, department, and telephone number (including area code and extension).

AGREEMENT COMPLETED BY: Enter the name, title, department, and telephone number (including area code and extension) of the person completing the agreement.
**********FOR MEDICAID USE ONLY**********

COMMENTS: Do not complete. This section will be completed by Medicaid staff.

SIGNATURE OF AUTHORIZING AGENT: Do not complete. This section will be signed and dated by Medicaid staff approving the ambulatory room and board services for the provider.

EFFECTIVE DATE: Do not complete. This will be completed by Medicaid staff as the date ambulatory room and board services are approved for the provider.

To view printable form click here: Ambulatory Room and Board Agreement

AMBULATORY ROOM AND BOARD AGREEMENT

NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
FINANCE AND SUPPORT

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM
Nebraska Department of Health and Human Services
Department of Finance and Support

Name of Hospital Facility		Date
Address		Medicaid Provider Number
City	State	Zip Code

Please Attach Additional Sheets if Necessary

Describe the ambulatory room and board facility including physical location (eg. distance from the hospital building, number of beds available, etc.)

List the services available to clients in ambulatory room and board (eg. meals, lodging, nursing, laundry service, etc.)

Ambulatory room and board charges:		Lodging Per Day		Meals per day
Client only	A0180		A0190	
Attendant only	A0200		A0210	
Client & an attendant	A0180-22			

Contact Person: person who can arrange ambulatory room and board services

Name	Title	Department	Phone Number

Agreement Completed By:

Name	Title	Department	Phone Number

FOR MEDICAID USE ONLY

Comments:

Signature of Authorizing Agent:	Effective Date: