



LTC-300R Automation

New Secure Site LTC-300R Menu Option

 **oklahoma health care authority**

Main Claims Eligibility Pricing Prior Auth **LTC-300R** Trade Files Account Mailbox Help Log Off

Provider Main Page Wednesday 6 February 2008 1:15 pm

If you have your NPI, please send it along with your Oklahoma Medicaid ID to:
Provider Enrollment
P.O. Box 54015
Oklahoma City, OK 73154

For information regarding NPI, please visit the [CMS website](#).

Provider Name: Nursing Home Provider
Provider Number: 123456789A
Taxonomy Number: 123456789X

- [Claim Submission](#)
- [Claim Inquiry](#)
- [Prior Authorization](#)
- [LTC-300R Online Application](#)
- [Eligibility Verification](#)
- [Pricing & Limitation](#) information for Procedures, Diagnosis, Drugs, and Revenue Codes
- [Error Codes Search](#)
- [Find prescriber ID numbers](#)

Your Remittance Advices, or 835 transactions, are being sent to:
Your physical address by mail in paper form.



LTC-300R Start Page



oklahoma health care authority



LTC-300R Online Form Submission

The LTC-300R Online Form allows you to complete the client assessment and submit it directly to the Oklahoma Health Care Authority.

[Learn more about using the LTC-300R Online Form.](#)

Before you start: It may be helpful to have a hard-copy of the completed form as you will not be able to save information for later completion.

Please enter the Client's SSN, Date of Birth, and Admission Date to begin the LTC-300R Online Form Submission process.

*** = Required Fields**

SSN:*

Date of Birth:*

Admission Date:*

Continue

Demographics from SoonerCare Enrollment or PASRR

* = Required Fields

SSN:*


Date of Birth:* 

Admission Date:* 

 The following client information is on file at the OHCA for the SSN and Date of Birth you entered:

Name	SLEEPY BEAR
SSN	123-45-6789
Date of Birth	05/31/1899
Gender	Female
DHS Case Number	

If this is the client for whom you wish to complete the assessment, select '**Continue**'.

If you would like to create a new record using the SSN and Date of Birth you entered, select '**Create New Record**'. 

If you would like to enter a different SSN and Date of Birth, select '**Start Over**'.

Start Over

Create New Record

Continue

Additional Demographics



oklahoma health care authority

Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Enter Client Demographics

Enter the Client Demographics requested below to continue with this client.

*** = Required Fields**

Race:* (check all that apply)

- African American
- Asian
- Caucasian
- Hawaiian/Pacific Islander
- Native American/Alaskan Native
- Other

Hispanic Ethnicity?* Yes No

Coverage:*

- Medicare
- Private Pay
- SoonerCare
- VA

Admission Type:*

- New Admission
- Transfer from other Nursing Facility

Prior Living Arrangement:*

Facility Discharge Date:*

Deceased Date:*

Cancel

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Continue

ADL Assessment



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Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Enter ADL Assessment

* = Required Fields

1. Grooming:*

- Independent
- Needs Help
- Total Assistance

4. Transferring:*

- Independent
- Needs Help
- Total Assistance

2. Bathing:*

- Independent
- Needs Help
- Total Assistance

5. Mobility:*

- Independent
- Needs Help
- Total Assistance

3. Eating:*

- Independent
- Needs Help
- Total Assistance

6. Bowel / Bladder Function:*

- Independent
- Needs Help
- Total Assistance

Rating Guide

Independent: Able to perform activity without supervision, reminder, or physical assistance from another person. Assistance with equipment to perform the activity is an "independent" response.

Needs Help: Requires supervision, reminder, or physical assistance, from another person during part of the activity.

Total Assistance: Completely unable to perform the activity without assistance from another person(s).

Cancel

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Continue

IADL Assessment

Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Enter IADL Assessment

* = Required Fields

7. Answers / Calls on Telephone:*

- Independent Needs Help Total Assistance

11. Laundry:*

- Independent Needs Help Total Assistance

8. Shopping / Errands:*

- Independent Needs Help Total Assistance

12. Housekeeping / Cleanliness:*

- Independent Needs Help Total Assistance

9. Arranges Transportation:*

- Independent Needs Help Total Assistance

13. Manages Money:*

- Independent Needs Help Total Assistance

10. Preparation of Meals:*

- Independent Needs Help Total Assistance

14. Manages Medication:*

- Independent Needs Help Total Assistance

Rating Guide

Independent: Able to perform activity without supervision, reminder, or physical assistance from another person. Assistance with equipment to perform the activity is an "independent" response.

Needs Help: Requires supervision, reminder, or physical assistance, from another person during part of the activity.

Total Assistance: Completely unable to perform the activity without assistance from another person(s).

Cancel

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Continue

Social Needs Assessment

Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Enter Social Needs Assessment

* = Required Fields

15. Diet:*

- Regular ?
- Modified
- Therapeutic
- Formula Only

20. Health Assessment:*

- Low Risk ?
- Moderate Risk
- High Risk

16. Communication:*

- Understandable ?
- Non-Verbal
- Unable to Communicate

21. Speech:*

- No Impairment ?
- Impairment
- Total Loss

17. Health Issues:*

- No Problem ?
- Some Problems
- Substantial Problems

22. Hearing:*

- No Impairment ?
- Impairment
- Total Loss

18. Consumer Support:*

- No Problem ?
- Some Problems
- Substantial Problems

23. Vision:*

- No Impairment ?
- Impairment
- Total Loss

19. Social Resources:*

- No Problem ?
- Some Problems
- Substantial Problems

Health Assessment



oklahoma health care authority

Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Enter Health Assessment

* = Required Fields

24. Heart Disease:* No Moderate Excessive

27. Diabetes:* No Moderate Excessive

25. Hypertension / Stroke:* No Moderate Excessive

28. Arthritic Conditions:* No Moderate Excessive

26. Emphysema / COPD:* No Moderate Excessive

29. Terminal Illness:* No Moderate Excessive

Rating Guide

No: Does not have the condition as diagnosed by a physician.

Moderate: Diagnosed with the condition by a physician. Requires frequent/intense medical oversight.

Excessive: Diagnosed with the condition by a physician. Requires high frequency/intensity of medical oversight. Condition is in end stage status.

Cancel

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Continue

Mental Status Assessment



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Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Enter Mental Status Assessment

* = Required Fields

30. Memory / Recall:*

- No Problem ?
- Some Problem
- Substantial Problem

38. Fearful:*

- No Problem ?
- Some Problem
- Substantial Problem

31. Irrational Behavior:*

- No Problem ?
- Some Problem
- Substantial Problem

39. Withdrawn:*

- No Problem ?
- Some Problem
- Substantial Problem

32. Confused:*

- No Problem ?
- Some Problem
- Substantial Problem

40. Aggressive:*

- No Problem ?
- Some Problem
- Substantial Problem

33. Impulsive:*

- No Problem ?
- Some Problem
- Substantial Problem

41. Refuses Activities:*

- No Problem ?
- Some Problem
- Substantial Problem

Rating Guide

No Problem: Shows no signs/symptoms of the condition. Has not been diagnosed with the condition by a physician.

Some Problem: Shows minor signs/symptoms of the condition. Has been diagnosed by a physician with the condition and is undergoing/responding well to treatment. Able to function well in society with treatment.

Substantial Problem: Demonstrating major signs/symptoms of the condition. Has been diagnosed by a physician with the condition. Is undergoing treatment. May require frequent/inpatient treatment. Not able to function in society. Cannot live independently.

Services Provided Screen

Name: SLEEPY BEAR

SSN: ###-##-6789

DOB: 05/31/1899



LTC-300R Online Form Submission - Enter Services Provided

For each service provided to the client, **enter the number** of times the service is provided per the selected time interval.

If the client does not need any of these services, select '**No Services Needed**'.

Services Needed

<input type="checkbox"/> Ventilator / Respirator	<input type="text" value="0"/> times per	<input type="text" value="Continuous"/> <input type="button" value="v"/>	Behavior Observation	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/> <input type="button" value="?"/>
<input checked="" type="checkbox"/> Decubitus / Lesion Care	<input type="text" value="1"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>	Catheter Care	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>
Medication Regulation	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>	Ostomy Care	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>
Retrain Bowel / Bladder	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>	Tracheal Care	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>
<input checked="" type="checkbox"/> Vital Signs Evaluation	<input type="text" value="7"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/> <input type="button" value="?"/>	Tube Feeding	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>
<input checked="" type="checkbox"/> Rehab, PT/OT	<input type="text" value="3"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>	Suctioning	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>
Speech Therapy	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>	<input checked="" type="checkbox"/> Injections	<input type="text" value="1"/> times per	<input type="text" value="Month"/> <input type="button" value="v"/>
Active Treatment	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/> <input type="button" value="?"/>	Isolation	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/> <input type="button" value="?"/>
Sterile Dressing	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>	IV Fluids	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/>
Intake and Output	<input type="text" value="0"/> times per	<input type="text" value="Week"/> <input type="button" value="v"/> <input type="button" value="?"/>	Oxygen	<input type="text" value="0"/> times per	<input type="text" value="Continuous"/> <input type="button" value="v"/>

No Services Needed

Cancel

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Continue

Diagnosis and Comments Screen

Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Enter Diagnosis

Enter the Primary Diagnosis and Code. Enter the Secondary Diagnosis and Code if applicable.

Enter any pertinent information in the Comments section.

*** = Required Fields**

Primary Diagnosis:*

Secondary Diagnosis:

Primary Diagnosis Code:

Secondary Diagnosis Code:

Comments:

Up to 256 characters can be entered in this section|

Up to 256 characters can be entered in the Comments section

Cancel

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Continue

PASRR Screen (Upper Half)

Name: SLEEPY BEAR

SSN: ###-##-6789

DOB: 05/31/1899



LTC-300R Online Form Submission - Enter Level I PASRR Information

Answer each question based on the client's condition **prior** to admission.

* = Required Fields

Person answering
Section E of the Form:*

Melanie Lawrence



Position:*

- Nursing Facility Authorized Official
- Hospital Authorized Official
- DHS Official

Does the client have:

1. Evidence of serious mental illness including possible disturbances in orientation or mood (dementia or other organic mental disorders are not considered a serious mental illness)?* Yes No
2. Diagnosis of a serious mental illness (for example, schizophrenic, paranoid, panic, mood or other severe anxiety or depressive disorder, somatoform disorder, personality disorder, or other psychotic disorder, or another mental disorder that may lead to a chronic disability)?* Yes No
3. Recent history of mental illness or been prescribed a psychotropic medication for a possibly undiagnosed mental illness in the absence of a justifiable neurological disorder within the last two years?* Yes No
4. Diagnosis of mental retardation or a related condition?* Yes No
5. History of mental retardation or a related condition?* Yes No

PASRR Screen (Lower Half)

6. Evidence of a possible mental retardation or related condition (cognitive or behavior functions)?* Yes No

THE CLIENT IS IS NOT A DANGER TO SELF OR OTHERS.*

Exempted Hospital Discharge:* Yes No

Short Term Stay Category:* Delirium Emergency Respite Not Applicable

Date of Consultation with LOCEU:

LOCEU Staff Name:

Consultation Decision and any Level II Evaluation Results:

Up to 256 characters can be inserted in this section.

Cancel

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Continue

Summary Screen Allows Review and Editing Before Submitting



oklahoma health care authority

Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Assessment Summary

Review the information you have entered. If everything looks correct, select "**Continue**". If any of the information is incorrect, select "**Edit**" to make changes to the section.

Client Demographics

Last Name:	BEAR	DHS Case Number:	
Suffix:		RID:	
First Name:	SLEEPY	Admission Type:	New Admission
Middle Initial:		Transferring Facility:	N/A
Race:	African American <input checked="" type="checkbox"/> Asian <input checked="" type="checkbox"/> Caucasian Hawaiian/Pacific Islander Native American/Alaskan Native Other	Prior Living Arrangement:	Intensive Care Facility / MR
Hispanic Ethnicity:	No	Facility Discharge Date:	
Gender:	Female	Deceased Date:	
Coverage:	Private Pay		

[Edit Demographics](#)

ADLs

Assessment Affirmation



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Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Assessment Affirmation

You **must** read the following statement, click the checkbox, and select '**Submit**' in order to complete the online assessment.

- I certify that, to the best of my knowledge, the foregoing information is true, accurate, and complete. I understand this information may be relied upon in payment of claims from Federal and State Funds, and that any willful falsification, or concealment of a material fact, may be prosecuted under Federal and State Law.



Cancel

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Submit

[Oklahoma's Medicaid Agency Accessibility Policy](#)

[Privacy Policy](#)

[Terms of Use](#)

Successful Submission Page with Tracking Number



oklahoma health care authority

Name: **SLEEPY BEAR**

SSN: **###-##-6789**

DOB: **05/31/1899**



LTC-300R Online Form Submission - Successful Submission

The LTC-300R for SLEEPY BEAR has been successfully submitted.

The Tracking Number is **T20090225249**

You should print a copy of the completed document to retain for your records. To do this:

- 1). Display the completed LTC-300R form by selecting the button below.
- 2). Once the completed form has been generated, select to "print it" from your computer.

[Display Completed LTC-300R](#)

If you don't have Adobe Acrobat Reader, you can [get Adobe Reader](#).



After you have printed the documents, you may:

- [Submit a form for another client.](#)
- [Return to the OHCA Provider Main Page.](#)

Implementation Plan

- Pilot scheduled April 2009
- State-wide go live in May/June 2009

Prerequisites to participate:

- SoonerCare Provider Specialty of 30 or 35
(Nursing Facility or Skilled Nursing Facility)
- Internet Access
- Internet Explorer 7.0
- OHCA Secure Site Access