Sandhills Center
Anson, Harnett, Hoke, Lee, Montgomery,
Moore, Randolph and Richmond Counties

NC Department of Health and Human Services

## ICF/MR Utilization Review Request Form

Agency Name__
Medicaid Provider #
Facility Name _
Contact Person
Address
Phone #
Utilization Review Date_____
Number of Level of Care Changes_____

**Return to Sandhills Center within 5 days of UR meeting to:**

**Sandhills Center**
Attn: **UM Department**
**P.O. Box 9**
**West End, NC 27376**

***Attach original Level of Care Eligibility Determination Tool for each member listed**

| Member Name | DOB | County # | Diagnosis Code | Medicaid ID # and Prior Authorization # | Level of Care Recommended | # of units | Authorization Period every 180 days (start & end dates) | Sandhills UM use ONLY |
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