

**MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES  
NURSING FACILITY ISOLATION BED REQUEST FORM**

INSTRUCTIONS: Fill out the below table with the facility information and for each beneficiary that you are requesting bed isolation for. This form must be submitted within 5 business days of the return of the isolated individual to their dually certified Medicaid Bed. The request must include the physicians' orders or other relevant documentation to substantiate the need for isolation. This form must be signed at the bottom and sent to [MDHHS-NFISOLATION@michigan.gov](mailto:MDHHS-NFISOLATION@michigan.gov) or by fax to 517-241-0066 if the facility is unable to send an encrypted email. Any questions may be sent to the above email address.

**Facility Information**

Facility Name	
Facility NPI Number	
Facility CCN Number	
Facility License Number	
Name of the Requestor	
Title of the Requestor	
Email of the Requestor	
Fax Number of the Facility	
Phone Number of the Requestor/Facility	
Date of the Request	

**Beneficiary Information**

Beneficiary Name	Beneficiary ID	Room Number of the Non-Medicaid Room	Room Number of the Current Room	Start Date	End Date	Number of days in the date range	Reason for Isolation

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date