

Nursing Facility Service Coordination Notification Form



Date: ____/____/____

This form is to be used to notify Superior HealthPlan's Service Coordination of the following: a Nursing Facility admission, a resident being admitted or discharged to the Emergency Room, hospital, hospice or another facility/home, Member death and/or any other adverse change in a Superior Member's condition.

Instructions: Complete all applicable sections prior to submission to your Service Coordinator.

Fax completed form to: 1-888-209-4584

For questions call: 1-877-277-9772

Facility Name: _____
 Vendor Number: _____
 Patient Name: _____
 Medicaid ID Number: _____
 Date of Birth: _____

Potential Change in Condition
 Significant, Adverse Change in Physical or Mental condition or environment that could **potentially** lead to hospitalization:

Requesting authorization/assistance for: _____

Admission Date: _____ Payor Change: _____
 Discharge Date: _____ Skilled Bed Date: _____
 Discharge to: _____ LTC Bed Date: _____
 Hospital _____
 Hospice _____
 Home _____
 Other _____
 Facility Name: _____
 Other _____

Emergency Room Visit Admission Date: _____ Time: _____
 Return Date: _____ Time: _____
 ER Facility: _____
 Reason: _____

Printed Name of Facility Representative: _____

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