

MEDICAID PATIENT STATUS NOTIFICATION

(To be submitted when a patient is admitted, discharged, transferred, or expires)

TO: Alabama Medicaid Agency
P.O. Box 5624-36103
501 Dexter Avenue
Montgomery, Alabama 36104

Date _____

FROM: _____ NPI Number _____
(Name of Facility)

(Address of Facility) Telephone Number _____

CURRENT PATIENT STATUS

Patient's First Name _____ M.I. _____ Patient's Last Name _____
_____/_____/_____ Birthdate _____
Patient's Social Security No. Female
Patient's Medicaid No. Male
Date Admitted _____/_____/_____ (Medicare Admission) _____ (Medicaid Admission)

Number of Medicare Days this Admission: _____

New Admission Hospital Mental Institution
 Re-Admission From: Home
 Transferred Admission Other Nursing Home _____

For Medicaid Use Only: Over 60-days late _____ Medicare Denial: _____
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Reference Information: _____ Name of Sponsor

Address of Sponsor

Mental Illness Developmentally Disabled
 Convalescent Care Post Extended Care Days Swing Bed Approved By _____
 Dual Diagnosis Mental Retardation Date Approved: _____

PATIENT DISCHARGE STATUS

Discharged to: _____ Date _____
Death (Date) _____

Signed _____
Title _____

Distribution:
White: Alabama Medicaid Agency
Canary: Office of Determination for Medicaid Eligibility - check one: SSI D.O.
Pink: Nursing Home File Copy

District Office

