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)

_____ Telephone Number _____
(Address of Facility)

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: _____

For Medicaid Use Only:
Over 60–days late _____
Medicare Denial: _____

☐ New Admission ☐ Hospital ☐ Mental Institutuion

☐ Re–Admission From: ☐ Home

☐ Transferred Admission ☐ Other Nursing Home _____

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

Form 199 (Formerly XIX-LTC-4)
Revised 2-13-08

THIS FORM MUST BE SUBMITTED TO MEDICAID WITHIN 60 DAYS OF MEDICAID ADMISSION DATE

Physician's current orders:
(a copy of orders may be attached)

PLEASE EXPLAIN REASON FOR HOSPITAL STAY OR POST EXTENDED CARE. (must be signed by an RN)

RN Signature

FOR POST EXTENDED HOSPITAL CARE ONLY:
(Please list nursing homes and dates they were contacted for placement. This form must be documented every 15 days.)

Nursing Home	Date Contacted

I CERTIFY THAT THIS RECIPIENT NEEDS NURSING HOME CARE
(Physician must sign and date)

Physician's Signature

Date