Clear Form

SKILLED NURSING HOME/ SWING BED ADMISSION NOTIFICATION FORM

FYI: Please submit this form to UCare upon admission, discharge and whenever there is an update or change within 24 hours. **Include the following:** Admission Assessment, therapy evaluations/ notes, discharge summary and copy of NONMC or NDMC if applicable.

For questions call: 612-676-3300 or 1-888-531-1493

Admissions: Fax form and relevant clinical documentation to: 612-884-2499

E-Mail: HCM_Fax@ucare.org

Concurrent Review: Fax form and relevant clinical documentation to: 612-884-2247

Email: SNF_fax@ucare.org

TYPE OF ADMISSON:	
☐ **Skilled Nursing Home Admission**	☐ **Swing Bed Admission**
Today's Date:	Date of Admission:

PATIENT INFORMATION:		
Name:		
Date of Birth:	Member ID:	
Address:		
City:	State:	Zip Code:
Phone:		

UCARE PLAN:

☐ UCare Medicare Plan
☐ EssentiaCare
☐ UCare Individual & Family Plan
☐ UCare Individual & Family Plan with M Health Fairview
☐ UCare Medicare Plan with M Health Fairview & North Memorial

***Please use Nursing Facility Communication Form (DHS-4461 form) for MSHO, MSC+, Connect + Medicare and Connect (SNBC) Plans.**

ADMITTING FROM FACILITY INFORMATION:			
Admission from:	☐ Community	☐ Hospital	☐ Lives in Nursing Home
Hospital Admission Date:		Hospital Discharge Date:	
Name of Hospital:			
Admission Diagnosis (ICD-10) Codes:			

ADMITTING TO FACILITY INFORMATION:	☐ CONTRACTED	☐ NON-CONTRACTED
Facility Name:		Facility NPI #:
Address:		
Phone:		

FACILITY CONTACT PERSON:			
Name:			
Phone:		Fax:	
Email:			
Preferred method of contact:	☐ Phone	☐ Fax	☐ Email

REASON FOR AUTHORIZATION REQUEST:

☐ Authorization/ Notification Request
☐ Benefit Exception:
☐ Out of Network Provider Requesting Network Exception

Admission/ Change/ Update/ Discharge:	Effective Date of Change/ Update:	Reason Codes:

REASON CODES:	
1. Intial Admission	6. Readmission (Hospital back to SNF)
2. Discharge (Home)	7. Transfer from another SNF
3. Discharge (Hospital)	8. Other Healthcare Facility
4. Discharge (Death)	9. Change in Medicare qualified stay/ End of benefit (Last covered day)
5. Hospice (Noncovered)	10. Other, please specify