NEVADA STATE DIVISION OF WELFARE AND SUPPORTIVE SERVICES

ADMIT / DISCHARGE / DEATH NOTICE

FOR NURSING, ICF/MR, AND ACUTE FACILITY TRACKING USE

(Must be submitted within 72 hours of occurrence or notification of pending Medicaid status)

DO NOT USE FOR LEVEL OF CARE CHANGES

SECTION I. Information in this section **MUST MATCH** Medicaid and Social Security records. Refer to patient's/resident's Medicaid Card, Legal Notice of Decision or access the Electronic Verification of Eligibility system. *(This section must be completed for **all** submissions.)*

Type of Medicaid Eligibility: *(Please check one)* ☐ MAABD ☐ Child Welfare ☐ TANF

CURRENT STATUS: ☐ Medicaid Eligible ☐ Medicaid Pending

Facility Submitting Form: *(Please do not use initials)*	Medicaid Provider Number:	Attending Physician:

Medicaid Billing No. (11 digits): ***(Please complete, even if pending)***	*Aid Code:	Social Security No.:	Date of Birth: MO DY YR _____ / _____ / _____	Sex: ☐ M ☐ F

Patient's/Resident's Last Name:	Patient's/Resident's First Name:	M.I.:

***Aid Code** to be completed if known by accessing one of the above three sources. DO NOT contact eligibility hot lines to obtain.*

If above information is for a newborn, complete the following:

Newborn's Mother's Last Name: First Name:	Medicaid Billing No. (11 digits):	Social Security No.:

SECTION II. Complete either Section A. or B.

A. ADMISSION INFORMATION: *(Complete this information **only** if being sent as an Admit Notice)*

ADMIT DATE TO THIS LEVEL OF CARE *(Regardless of Payment Source)*

MO DY YR

_____ / _____ / _____

*** ADM CODE:** *(See below)*	**Patient/Resident Admitted From:** *(Include name. Do not use initials.)*

B. DISCHARGE/DEATH INFORMATION: *(Complete this area **only** if being sent as a Discharge/Death Notice)*

DISCHARGE OR DEATH DATE:

MO DY YR

_____ / _____ / _____

WAS THIS STAY PRIMARY MEDICARE?

(for nursing facility discharges only)

☐ YES ☐ NO

****DIS CODE:** *(See below)*	**Patient/Resident Discharged To:** *(Include name)*

Notice Completed by: _____ Telephone: _____

***ADM(ission) Code:**
B from ACUTE Level
C from SKILLED NURSING Level
D from INTERMEDIATE CARE Level
E from INDEPENDENT LIVING

****DIS(charge) Code:**
B to ACUTE Level
C to SKILLED NURSING Level
D to INTERMEDIATE CARE Level
E to INDEPENDENT LIVING Arrangement
F PATIENT/RESIDENT DECEASED

SEND TO THE LOCAL DISTRICT OFFICE.