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.**