

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. <i>(This section must be completed for all submissions.)</i>				
Type of Medicaid Eligibility: <i>(Please check one)</i> <input type="checkbox"/> MAABD <input type="checkbox"/> Child Welfare <input type="checkbox"/> TANF				
CURRENT STATUS: <input type="checkbox"/> Medicaid Eligible <input type="checkbox"/> Medicaid Pending				
Facility Submitting Form: <i>(Please do not use initials)</i>		Medicaid Provider Number:		Attending Physician:
Medicaid Billing No. (11 digits): <i>(Please complete, even if pending)</i>	*Aid Code:	Social Security No.:	Date of Birth: MO DY YR ____ / ____ / ____	Sex: <input type="checkbox"/> M <input type="checkbox"/> 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. <u>DO NOT</u> 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: <i>(Complete this information only if being sent as an Admit Notice)</i>				
ADMIT DATE TO THIS LEVEL OF CARE <i>(Regardless of Payment Source)</i>				
MO DY YR ____ / ____ / ____				
* ADM CODE: <i>(See below)</i>	Patient/Resident Admitted From: <i>(Include name. Do not use initials.)</i>			
B. DISCHARGE/DEATH INFORMATION: <i>(Complete this area only if being sent as a Discharge/Death Notice)</i>				
DISCHARGE OR DEATH DATE:			WAS THIS STAY PRIMARY MEDICARE?	
MO DY YR ____ / ____ / ____			<i>(for nursing facility discharges only)</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	
		** DIS CODE: <i>(See below)</i>	Patient/Resident Discharged To: <i>(Include name)</i>	
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.