

NURSING HOME FAX COVER SHEET

Date:

TO:

PREADMISSION REVIEW PHONE: _____

TOLL FREE: _____

INTAKE/SCREENING PHONE: _____

PAR FAX NUMBER: _____

FROM:

Facility Name: _____

Contact Person: _____

Phone Number: _____

Fax Number: _____

Client Name: _____

(PLEASE PRINT CLIENT'S NAME ON EACH PAGE)

REQUESTING: For Non-Medicaid Individuals

(Please check one)

_____ Expired respite stay, needs assessment

_____ Expired convalescent stay, needs assessment

_____ New admission from community

_____ Transfer or readmission with substantial improvement, needs
assessment

_____ Other

(explain) _____

For Medicaid Individuals

_____ New admission from community

_____ Change of vendor payment

_____ LOC for NF-to-NF transfer

_____ Other

(explain) _____

REFAXING

ADDITIONAL INFO. Requested by: _____

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