PHP Notification of Nursing Facility Level of Care

To be completed by Health Plan

Member Information

Last Name: _____
First Name: _____
DOB: _____
Gender: ☐ M ☐ F
MID #: _____

Assigned Health Plan Information (Standard or Tailored Plan)

Health Plan Name: _____
Health Plan Contact: _____
Health Plan Contact Phone Number: _____
Health Plan Contact Email Address (Optional): _____

Level of Care Information:

Previous level of Care: ☐Home ☐SNF ☐ICF ☐Hospital ☐Dom ☐Other_____
If applicable, previous hospital/facility name & discharge date _____
NF Level of Care Approved by PHP: ☐ Yes ☐No
Effective Date of NF Level of Care Approval: _____

Name: _____
(Enter Name of Health Plan Representative)
Date: _____
(Enter Date of Approval)

To be completed by NF or Hospital*

Admitting Nursing Facility or Hospital Information:

Facility/Hospital Name: _____
Facility/Hospital Address: _____
NF/Hospital Contact Name: _____
NF/Hospital Contact Phone Number: _____
NF/Hospital Contact Email Address: _____
Member's admission date to facility/hospital: _____
Member's Last 4 of SSN: _____
Authorized Representative Name, Address & Phone Number:
_____
_____
_____

*NOTE: In addition to NF, if the approval is for nursing facility level of care or a Swing Bed in a hospital, the hospital should fill out the above section.