

Exhibit 2 – Nursing Home/Facility Admission Notification Form

NURSING HOME/FACILITY ADMISSION NOTIFICATION

Independent Care Health Plan (iCare) reviews all admissions for medical necessity and appropriateness of level of care. In order to conduct these reviews on a timely basis, policy **REQUIRES** the facility to notify iCare of all facility stays **within one (1) business day** of the admission. Failure to adhere to iCare’s notification policy may result in delay or denial of payment of the related facility claim.

Please enter all requested information on this form and fax to iCare at FAX# 414-231-1075.

All requested information must be provided. If you have any questions about this policy please contact iCare at 414-223-4847. Submission of the notification of an admission is not a guarantee of coverage or payment of the reported service.

MEMBER INFORMATION:

Name: _____ Medicaid ID#: _____
DOB: _____ Medicare ID#: _____

SKILLED NURSING FACILITIES

Is member’s coverage Medicare-prime? Yes No (Medicare iCare Medicare other)
If yes, is the member being admitted to a Medicare-certified bed? Yes No
If no, why not? _____

ADMISSION INFORMATION:

Admission Date: _____ Admitted from _____ Hospital _____
Admitting Facility: _____ Facility Phone #: _____
Admitting MD: _____ Admitting MD’s Phone #: _____
Admitting Dx: 1. _____ ICD9 Code: _____
2. _____ ICD9 Code: _____
Designated Contact Person: _____ Title: _____
Phone: (_____) _____ Fax: (_____) _____

Confidentiality Notice: This facsimile transmittal contains confidential information belonging to the sender which is legally privileged. The information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance of the contents of this confidential information is strictly prohibited. If you receive this communication in error, please notify us immediately at 414-223-4847. Thank you.

===== **DO NOT WRITE BELOW THIS LINE** =====
Date Received: _____ Received By: _____ Notification Auth# _____
CC/CM: _____ RN Case Manager/DC Planner: _____