NURSING FACILITY DISCHARGE/TRANSFER/HOSPICE FORM

(To be completed by the Discharging/Transferring/Hospice Nursing Facility and submitted to the Member's MCO)

Member Information:

Name Last_____ Name First_____ DOB_____/_____/_____MCO ID _____ SSN_____

Representative/Designee/Power of Attorney:

☐ **Member Elects to Receive Hospice in the NF**

Last_____ First_____ Phone (_____)_____-_____ Hospice Effective Date: ____/____/_____
MCO submits to TennCare LTSS only – Disenroll CHOICES

Discharging/Transferring/Hospice Nursing Facility: NF/SNF Provider #

_____ _____

City: _____County: _____State:_____

(_____)_____-_____ _____
Phone Contact Name

Member Discharging To: **Date of Discharge** ____/____/_____

- ☐ **Another NF** – Discharging/Transferring NF completes the "Receiving Nursing Facility" box at right.
  (MCO submits copy to TNHC only to update address.)
- ☐ **Home with CHOICES HCBS** (Transition to Group 2 or 3)
  (MCO submits to TennCare LTSS and LTSS submits to Member Services via TPAES.)
- ☐ **Home without CHOICES HCBS** (Disenroll from CHOICES.)
  (MCO submits copy to TennCare LTSS and TNHC.)
- ☐ **N/A – Member deceased**
  (MCO submits copy to TennCare LTSS)
- ☐ **Hospital** (Upon hospital discharge, MCO completes as follows):

FOR MCO USE ONLY:

- ☐ Re-admitted to Discharging Facility
- ☐ Admitted to another NF
  (MCO completes "Receiving Nursing Facility" box at right and submits to TNHC only to update address.)
- ☐ Member deceased
  (MCO submits copy to TennCare LTSS)
- ☐ Home with CHOICES HCBS (Transition to Group 2 or 3)
  (MCO submits to TennCare LTSS and LTSS submits to Member Services via TPAES.)
- ☐ Home without CHOICES HCBS (Disenroll from CHOICES.)
  (MCO submits copy to TennCare LTSS and TNHC.)

Receiving Nursing Facility (IF applicable): NF/SNF Provider #

_____ _____

City: _____County: _____State: _____

(_____)_____-_____ _____
Phone Contact Name

NF Admission Date: _____/_____/_____

Approved PAE(s) Control Number_____
Effective Dates:

____/____/_____ thru ____/____/_____

☐ Enhanced Respiratory Care (indicate below):

- ☐ Vent Weaning ____/____/_____ thru ____/____/_____
- ☐ Chronic Vent ____/____/_____ thru ____/____/_____
- ☐ Tracheal Suctioning ____/____/_____ thru ____/____/_____

COMMENTS:

Check Member MCO below and fax completed form to Member's MCO at the number specified below:

☐ United HealthCare	☐ AMERIGROUP	☐ BlueCare/TennCare Select
1-888-582-1963	**1-888-762-3203**	**855-273-5838**