MEDICAID PATIENT STATUS NOTIFICATION

(To be submitted when a patient is admitted, discharged, transferred, or expires)

TO: Alabama Medicaid Agency
P.O Box 5624-36103
501 Dexter Avenue
Montgomery, Alabama 36104

Date ______________________________

FROM: ___________________________________
(Name of Facility)

NPI Number ______________________________

____
(Address if Facility)

Telephone Number________________________

CURRENT PATIENT STATUS

Patient's First Name M.I Patient's Last Name
__________________ /______ /____________________ Birthdate________________________

Patient's Medicaid No. ______________________________

Female

Male

Date Admitted ____________________________/____________________________________
(Medicare Admission) (Medicaid Admission)

For Medicaid Use only:	
Over 60-days late	_____
Medicare Denial	_____

Number of Medicare Days this Admission: ____________________

New Admission
Re-Admission
Transferred Admission

From:

Hospital
Home
Other Nursing Home: ___________________

Reference Information: ____
Name of Sponsor

____
Address of Sponsor

Mental Illness
Convalescent Care
Dual Diagnosis

Developmentally Disabled
Post Extended Care Days
Intellectually Disabled

Swing Bed

Approved By __________________________

Date Approved _________________________

PATIENT DISCHARGE STATUS

Discharged to ____ Date ______________________________

Death (Date) ____

Signed _______________________________________

Title _______________________________________

Form 199 (Formerly XIX-LTC-4)
Revised 3-6-23

THIS FORM MUST BE SUBMITTED TO MEDICAID WITHIN 60 DAYS OF MEDICAID ADMISSION DATE

Physician's current orders:
(a copy of orders may be attached)

PLEASE EXPLAIN REASON FOR HOSPITAL STAY OR POST EXTENDED CARE. (must be signed by a RN)

RN Signature

FOR POST EXTENDED HOSPITAL CARE ONLY:
(Please list nursing homes and dates they were contacted for placement. This form must be documented every 15 days.)

Nursing Home	Date Contacted

I CERIFY THAT THIS RECIPIENT NEEDS NURSING HOME CARE
(Physician must sign and date)

Physician's Signature

Date

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