

# MLTSS Facility Alert Form

Date of Notification:		
<b>Member Information</b>		
<input type="checkbox"/> New to HNJH Medicaid;	Date of Admission:	Date of Medicaid Eligibility/Financial Spend down (For Assisted Living only):
Member Name:		
Member ID:		
<b>Provider Information</b>		
Provider/Facility Name:		
Provider ID:		
<b>IDT Meeting</b>		
Expected Meeting Date: <small>Requires 7 day prior notification</small>		
<b>Hospital Admission Alert / Emergency Room Alert (regardless of the primary payer)</b>		
Admission Date:	Hospital Name:	Return to Facility Date:
<b>Covid-19 Isolation/Facility Quarantine Alert</b>		
Date:	Details:	
<b>Fall Alert</b>		
Date of Fall:	Medical Attention Required (Y/N):	Reason for Fall:
<b>Notification of Death</b>		
Date of Action:		
<b>Transition to Community</b>		
Date of Action:		
<b>Comments:</b>		
Completed By:		
Phone Number:		

**To report an incident, please fax this form to Horizon NJ Health's MLTSS staff at 1-973-274-3864 or email to [MLTSS\\_Alerts@HorizonBlue.com](mailto:MLTSS_Alerts@HorizonBlue.com).**