

MLTSS Facility Alert Form

Date of Notification:		
Member Information		
_ New to HNJH Medicaid;		Date of Medicaid Eligibility/Financial Spend down (For Assisted Living only):
Member Name:		• •
Member ID:		
Provider Information		
Provider/Facility Name:		
Provider ID:		
IDT Meeting		
Expected Meeting Date: Requires 7 day prior notification		
Hospital Admission Alert / Emergency Room Alert (regardless of the primary payer)		
Admission Date:	Hospital Name:	Return to Facility Date:
Covid-19 Isolation/Fac	cility Quarantine Alert	
Date:	Details:	
Fall Alert		
Date of Fall:	Medical Attention Required (Y/N):	Reason for Fall:
Notification of Death		
Date of Action:		
Transition to Commun	ity	
Date of Action:		
Comments:		
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.

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