**Nursing Home Provider** complete and send form tofax number: **608-785-6315** or email to: [absenceandchangereporting@inclusa.org](mailto:absenceandchangereporting@inclusa.org) Please use one form per member.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| This section *must be* completed and submitted to Inclusa within 24 hours of absence, or by Monday morning if absence occurs during weekend/holiday hours, if the member does not return within 24 hours. | | | | | | | | | | |
| **Date Completed**: | |  | | | | | **Member Name**: |  | | |
| **Provider Name**: | |  | | | | | | | | |
| **Community Resource Coordinator**: | |  | | | | | **Health & Wellness Coordinator**: |  | | |
| **Submitted By**: | |  | | | | | **Submitter Phone Number**: | | |  |
| **Date/Time Care Conference Scheduled:** | | | | | |  | | | | |
|  | | | | | | | | | | |
| **Change in Inclusa Member RUGS** | | | | | | | | | | |
| **New RUGS**: |  | | | | **Effective Date of New RUGS:** | | | | | |
| **Reason for MDS Review:** | Change in therapies  Scheduled MDS  Change in Condition | | | | | | | | | |
|  | | | | | | | | | | |
| **Member Enrolled in Hospice Care:** | | | | **Date:** | | | | | | |
|  | | | | | | | | | | |
| **Member Absence from Nursing Home** | | | | | | | | | | |
| **Date Member Left:** | | |  | | | | | | | |
| **Reason for Absence:** | | |  | | | | | | | |
| **Expected Length of Absence:** | | |  | | | | | | | |
| **Date of Return, if Known:** | | |  | | | | | | Unknown | |
| ***Bed Hold Request (provider must certify required occupancy below)*** | | | | | | | | | | |
| **Nursing Home provider hereby certifies that the provider’s facility meets the Medical Assistance occupancy requirements qualifying for bed hold reimbursement.** | | | | | | | | | | |
| **Printed Name and Title:**  *(If completing this form electronically, printed name and title will suffice as Authorized Signature).* | | | | | | | | | | |
| **Authorized Signature:** | | | | | | | | | | |

***Internal Directions:*** *Receptionist send to AES. \*Hospitalizations greater than 10 days require a Family Care Change Form submitted to the Change Routing Form mailbox.*