**Nursing Home Provider**: Complete and send form tofax number: **866-880-0551** or email to: [absenceandchangereporting@inclusa.org](mailto:absenceandchangereporting@inclusa.org). Please use one form per member.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 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 or email**: | | |  | | |
| **Date/Time Care Conference Scheduled:** | | | | | | |  | | | | | | |
|  | | | | | | | | | | | | | |
| **Change in Inclusa Member HIPPS score**  **Note: HIPPS scores should not be reported if the Inclusa Member is enrolled in Hospice or has Medicare as primary insurance** | | | | | | | | | | | | | |
| **New HIPPS**: |  | | | | | **Effective Date of New HIPPS:** | | | | | | | |
| **Reason for MDS Review:** | Change in therapies  Scheduled MDS  Change in Condition  Change in funding from Medicare to Inclusa as primary | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  |
| **Date enrolled in Hospice:** Click or tap to enter a date.  **Date disenrolled From Hospice:** Click or tap to enter a date.  **Date Medicare started Coverage:** Click or tap to enter a 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:** | | | |  | | | | | | | |  | |
|  | | |  | | | | | | | | | | |