



County

PROVIDER COMMUNICATION

To				From			
Response Requested <input type="checkbox"/> For your information <input type="checkbox"/>							
Member Name							
	<i>Last</i>			<i>First</i>		<i>Middle</i>	
Medicaid #							

A. STATUS CHANGE (suspend/resume)			
_____ Hospital Admission Date			_____ Hospital Discharge Date
_____ Vacation Begin Date			_____ Vacation End Date
_____ Temp Nursing Facility Placement Date			_____ Discharge Date
_____ Other Begin Date _____			_____ Other End Date

B. ACTION (if applicable)	
<input type="checkbox"/> Suspend Services Effective Date _____	<input type="checkbox"/> Resume Services Effective Date _____

C. ADDITIONAL COMMENTS RELATED TO STATUS CHANGE
Justification for change:
If hospitalization or temporary nursing facility placement occurred, explain:

D. COMMENTS/OTHER

E. DISTRIBUTION
Cc: _____

Submitted by	Agency	Date