

STATE OF OKLAHOMA
DEPARTMENT OF HUMAN SERVICES

**NOTIFICATION REGARDING PATIENT IN A NURSING FACILITY (NF),
INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR), OR HOSPICE**

TO:

Oklahoma Department of Human Services (OKDHS) county office			
County address	City	State	Zip

FROM:

Facility	City		State	Zip	Provider number
Address	City	State	Zip		

RE:

Name of patient	Client identification (ID) number		Case number		
Former address	City	State	Zip		
Social Security or health insurance benefit (HIB) number	Date of birth	Sex	Race		

Patient is in a Title XVIII certified bed.

SECTION I. **ADMISSION.** Patient was admitted to this facility on (date): _____ from (previous location): _____

Medicaid financial eligibility approved? Yes No

Medicaid medical eligibility approved? Yes No

New patient:

NF admission. Oklahoma Health Care Authority Form LTC-300A, PASRR Level 1 Screen, signed physician's order for nursing care, and a plan of care are on file in the facility (not applicable on ICF/MR admissions).

ICF/MR admission. A report of psychological testing performed within the last 12 months and a plan of care for this patient, signed by a physician, are on file in the facility (not applicable on NF admissions.)

Hospice admission. Eligible recipient's election statement and plan of care are on file in the facility.

Returned from hospital:

Name of hospital			
Patient's physician			
Physician's address	City	State	Zip

SECTION II. **DISCHARGE.** This is to notify you that the above named individual was discharged from this facility on (date): _____

Discharged to (place): _____

Entered hospital (name of hospital): _____

Date deceased: _____

Signature of operator

Date

OKDHS USE ONLY: Patient's initial continued stay review date: _____
Date Form ABCDM-83 returned to facility: _____

Purpose of Form

Form ABCDM-83 is a multi-purpose form provided by the Oklahoma Department of Human Services (OKDHS) to operators of nursing facilities, ICF/MR facilities, and hospices for their convenience to:

- notify OKDHS of an admission or discharge of a patient on whose behalf Oklahoma Health Care Authority (OHCA) is making a payment for care;
- notify OKDHS of the admission of a patient who wishes to make an application for help with his or her expenses for care;
- notify the Social Security Administration when a recipient of Supplemental Security Income (SSI) is admitted; and
- assign an initial continued stay review date.

Early notification of a change in a patient's status aids in processing claims accurately and in providing assistance to patients who wish to make application.

Instructions for Preparation of Form

To: Enter the address of the OKDHS county office.

From: Enter the name, address, and provider number of the facility or hospice submitting the form.

Re: Enter the patient's name and former address; client identification (ID) number; Medicaid case number, if any; Social Security or HIB number; date of birth; sex; and race. Indicate if patient is in a Title XVIII certified bed.

SECTION I. ADMISSION. If the notification is for the patient's admission, enter the date admitted as well as immediate previous location and check to indicate whether the patient is new at this facility or is returning from a hospital stay. **If known, check whether the patient's Medicaid financial and medical eligibility is approved.**

NF admission: If the patient is new and being admitted to a nursing facility, check NF admission to indicate if the Oklahoma Health Care Authority Form LTC-300A, PASRR Level I Screen, allows admittance and whether a plan of care for the patient, signed by a physician, is on file in the facility.

ICF/MR admission: If the patient is new and being admitted to an ICF/MR facility, check ICF/MR admission to indicate if a report of psychological testing performed within the last 12 months, and a plan of care for the patient, signed by a physician, is on file in the facility.

Hospice admission: Check hospice admission if eligible client elects hospice care. The nursing facility retains a copy of the client's hospice election statement and current plan of care.

If the patient is returning from the hospital, enter the name of the hospital. Enter the name of the physician and the physician's address.

SECTION II. DISCHARGE. If the notification is for a patient leaving the facility, enter the date discharged. Check the appropriate block to show that the patient was discharged to some other living arrangement, entered a hospital and indicate which hospital, or that the patient died and the date of death.

Signature: The operator or representative must sign and date the form.

Routing of Form

The original form must be sent to the OKDHS county office no later than five days after a patient is admitted or discharged. If the recipient receives SSI, mail a copy to the local Social Security Office. The remaining copy is retained by the facility.