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This form is for long-term care (LTC) discharge notification only. Please complete and fax to Santa Clara Family Health Plan (SCFHP) Utilization Management (UM) Department at **1-408-874-1957** within 24 hours of any LTC discharge. This does NOT include transfers to acute settings. If you have any questions, please call UM Department at **1-408-874-1821**.

Today's Date: \_\_\_\_\_

Member Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Plan:  Cal MediConnect  Medi-Cal

Original Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Discharge Location: \_\_\_\_\_

Reason for Discharge (e.g. hospice, expired, last covered day):  
\_\_\_\_\_  
\_\_\_\_\_

Facility: \_\_\_\_\_

**REQUIRED CHECKLIST BEFORE SUBMISSION** Discharge Plan is attached, *or* Discharge Summary is attached.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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