Santa Clara Family Health Plan™

Long-Term Care Discharge Notification Form

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: _____