MAINE DEPARTMENT OF HEALTH & HUMAN SERVICES

TRANSFER FORM for NURSING FACILITY MAINECARE MEMBER ONLY

IF NOT A MAINECARE MEMBER, DO NOT COMPLETE THIS FORM.

Member Name: _____ MaineCare Number: ☐☐☐☐☐☐☐☐☐

Facility/Agency Name: _____

Facility/Agency Telephone #_____ Facility/Agency Fax #_____

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☐ **NEW ADMIT TO YOUR FACILITY (send to KeyPro Fax# 1-844-356-7500 and OADS Fax# 287-9231)**

Admit Date _____

Is this transfer from another nursing facility? ☐ Yes Facility Name:_____ ☐ No

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☐ **HOSPITAL TRANSFERS (send only to OADS Fax# 287-9231)**

- ☐ Hospital: **Bedhold Request** (required if hospital stay > 24 hours)

  Hospital name_____ Date _____

- ☐ Your nursing facility on return from hospital
  - ☐ to SNF Medicare Date _____
  - ☐ to NF MaineCare Date _____

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☐ **OTHER TRANSFERS (send only to OADS Fax# 287-9231)**

- ☐ from SNF Medicare back to NF MaineCare First non-SNF Date _____
- ☐ from NF MaineCare to SNF Medicare within 30 days of admit Date _____
- ☐ from NF MaineCare to Private Pay Date _____

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☐ **DISCHARGED TO (send only to OADS Fax# 287-9231)**

- ☐ Home Address_____ Date _____
- ☐ Residential Care (name) _____ Date _____
- ☐ Other Nursing Facility (name)_____ Date _____
- ☐ Hospice House (name) _____ Date _____
- ☐ Hospital (name) _____ Date _____

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☐ **DECEASED (send only to OADS Fax# 287-9231)** Date _____

Specify location at time of death: ☐ NF ☐ Hospital

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Signature of person completing this form: _____Date Submitted: _____