DELAWARE HEALTH AND SOCIAL SERVICES

Division of Medicaid & Medical Assistance

# Diamond State Health Plan Plus (DSHP Plus)

## CHANGE FORM

**Member Name:**

Last_____ First_____ MI_____ DOB _____/_____/_____ DE Medicaid ID # _____

**Representative/Designee/Power of Attorney:**

Last_____ First_____ Phone (____)_____

**Discharging -Transferring NF or Current Home Address:** **NF/SNF Provider #**

NF:_____ _____

_____

City: _____ State: _____ Zip:_____

(_____) _____-_____ _____

Phone Contact Name

**Member Discharging To:** **Date of Discharge** _____/_____/_____

- ☐ Another NF – Discharging/Transferring NF(complete NF box at right)
- ☐ Home (complete receiving address at right)
- ☐ MFP (complete receiving address at right)
- ☐ N/A – Member Deceased – **DOD** _____/_____/_____
- ☐ Hospital (Upon discharge, complete as follows):
  - ☐ Admitted to another NF(complete NF box at right)
  - ■ Member Deceased **DOD** _____/_____/_____
  - ☐ Home (complete receiving address at right)
  - ☐ MFP (complete receiving address at right)
- ☐ MCO unable to reach client for 30 Days
- ☐ MCO Identifies client not receiving services for over 2 weeks

**Receiving Nursing Facility or New/Current Home Address:** **NF/SNF Provider #**

NF:_____ _____

_____

City: _____ State: _____ Zip:_____

(_____) _____-_____ _____

Phone Contact Name

**Member Admitted To Nursing Facility from Community:** (complete above)
**Date of Admission**_____/_____/_____

☐ **PAE and required documentation sent**

**COMMENTS**:

☐ **UnitedHealthcare** ☐ **DPCI**

Revised 1/23/2012