# County Hospital Home Health

## PATIENT MASTER UPDATE FORM

**ACTION CODE** ☐ CHANGE ADDRESS PAYER M.D. ☐ DISCHARGE FROM AGENCY ☐ OASIS

01-Caldwell
02-Lyon
03-Trigg
☐☐

**PATIENT NUMBER** ☐☐☐☐☐☐☐☐☐

**A. NAME** _____ LAST _____ FIRST _____ M.I.

**B. ADDRESS** _____ STREET _____ CITY _____ STATE _____ ZIP

**C. STATUS/AGENCY** ☐ ACTIVE ☐ DISCHARGE DATE ☐☐ ☐☐ ☐☐

**DISCHARGE REASON**

___ Client Stabilized
___ Patient Recovered
___ Patient Moved
___ Refused Services
___ No Longer Homebound
___ Admitted To Hospital
Hospital_____
___ Admitted To N.H.
___ Died At Home
___ Died In Hospital
___ Other_____
_____
___ Not Admitted

**D. OASIS** ☐☐-☐☐-☐☐

**RESUMPTION OF CARE** ☐☐-☐☐-☐☐

**TRANSFER DATE** ☐☐-☐☐-☐☐

**DISCHARGE DATE** ☐☐-☐☐-☐☐

**SOC** ☐☐-☐☐-☐☐

**SCIC**

**PRIMARY BILLING**

- ☐ H.H.
- ☐ WAIVER
- ☐ MEDICAID
- ☐ PRIVATE PAY
- ☐ MEDICARE A
- ☐ MEDICARE B
- ☐ MEDICAID (K.M.A.P.)
- ☐ BC/BS
- ☐ CHAMPUS
- ☐ PRIVATE INSURANCE
- ☐ VA
- ☐ PRIVATE PAY
- ☐ HCBW
- ☐ HCBW-PRIVATE PAY
- ☐ AETNA
- ☐ WORKMAN'S COMP.

**SECONDARY BILLING**

- ☐ SELF
- ☐ PRIVATE INS.
- ☐ BC & BS
- ☐ EMPLOYER
- ☐ MEDICAID
- ☐ OTHER

Medicare Number ☐☐☐☐☐☐☐☐☐☐☐☐
Eff. Date ☐☐-☐☐-☐☐
KMAP Number ☐☐☐☐☐☐☐☐☐☐
Eff. Date ☐☐-☐☐-☐☐
☐☐-☐☐-☐☐
PAYOR CHANGE EFFECTIVE DATE

**INSURANCE DESCRIPTION** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐ GROUP _____ ☐ CERT. # _____
☐ EFFECT DATE _____

☐ **E** DOCTOR _____ NO. ☐☐☐☐ ☐☐-☐☐-☐☐ ☐☐-☐☐-☐☐

HOSPITAL _____ NO. ☐☐☐☐ Stay From ☐☐-☐☐-☐☐ To ☐☐-☐☐-☐☐

☐ **F** ILLNESS

| | | DATE | SEVERITY |
|---|---|---|---|
| ☐☐☐-☐☐ | DIAGNOSIS ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ | ☐☐ ☐☐ ☐☐ | ____ |
| ☐☐☐-☐☐ | DIAGNOSIS ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ | ☐☐ ☐☐ ☐☐ | ____ |
| ☐☐☐-☐☐ | DIAGNOSIS ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ | ☐☐ ☐☐ ☐☐ | ____ |

☐ **G** PATIENT INFORMATION

LOCALITY_____ ☐☐☐

LIVES ALONE 1 ☐
LIVES WITH OTHERS 0 ☐

PHONE 2 7 0 (AREA) ☐☐☐☐☐☐☐ (NUMBER)

EMPLOYEE ☐☐☐☐☐☐