



**Fax notification to: 888-633-4052**

**Critical Access Hospital Swing Bed Notification Form**

HOSPITAL NAME	
SWING BED ADMISSION DATE	SWING BED DISCHARGE DATE
MEMBER FIRST NAME	MEMBER LAST NAME
SCHA ID #	MEMBER DATE OF BIRTH
IS THE SWING BED FACILITY ATTACHED TO THE HOSPITAL TO WHICH THE MEMBER WAS ORIGINALLY ADMITTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
TRANSFER TO SWING BED FROM? <input type="checkbox"/> HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> SNF <input type="checkbox"/> OTHER DESCRIBE OTHER	
ANTICIPATED LENGTH OF STAY? <input type="checkbox"/> 0-5 DAYS <input type="checkbox"/> 6-14 DAYS <input type="checkbox"/> 15-30 DAYS	
COMPLETED BY FIRST NAME	COMPLETED BY LAST NAME
PHONE NUMBER	FAX NUMBER
NOTES	

**Contact the Provider Call Center at 888-633-4055 for questions related to claims.**

**Contact Utilization Management at 888-633-4051 for questions related to the notification form.**

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