South Country HEALTH ALLIANCE

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

# Critical Access Hospital Swing Bed Notification Form

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|---|---|
| HOSPITAL NAME | |
| SWING BED<br>ADMISSION DATE | SWING BED<br>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? ☐ YES ☐ NO | |
| TRANSFER TO SWING BED FROM? ☐ HOME ☐ HOSPITAL ☐ SNF ☐ OTHER DESCRIBE OTHER | |
| ANTICIPATED LENGTH OF STAY? ☐ 0-5 DAYS ☐ 6-14 DAYS ☐ 15-30 DAYS | |
| COMPLETED BY<br>FIRST NAME | COMPLETED BY<br>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.***





Clear Form