FAX

Date:	02/05/2026
Pages including cover sheet:	3

To:	
Phone	
Fax Phone	*+19725329272*

From:	Arpit Patel
Phone	+18884110212X701
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NOTE:

Packet Routing Fax from PG : To: 19725329272, referenced id: 705136

Ohio Department of Medicaid

FACILITY COMMUNICATION

The purpose of the form is to report admissions and discharges of nursing facility residents. Required fields are marked with an asterisk (*), but only the required fields within the section that is being completed by the submitter must be answered.

I. RESIDENT INFORMATION		
First Name* Tana	**Last Name*** Aguero	**Middle Initial**
Medicaid Number *(12 digits)* 996524898696	**Social Security Number*** 268-20-1600	**Date of Birth** *(mm/dd/yyyy)* 11/01/1995
If individual does not have a Medicaid Number, has a Medicaid application been submitted? ☐ Yes *(provide application date)* ☐ No ☐ Unknown		**Application Date** *(mm/dd/yyyy)*

II. FACILITY INFORMATION – ADMISSION OR NF TRANSFER	
Admission Date *(mm/dd/yyyy)** 10/11/2025	**Type of Admission*** ☐ Fee-For-Service *(submit to PAA)* ☑ Managed Care *(submit to ODM)* ☐ New Medicaid Applicant *(submit to PAA)* Plan Name: New Health Care
Comments: Comments by Facility:- Client was admitted from hospital for ...See Next Page	

III. FACILITY INFORMATION – DISCHARGE, DEATH OR NF TRANSFER		
Date of Discharge* *(mm/dd/yyyy)* 10/15/2025		
Reason for Discharge*		
☐ Waiver Enrollment	☐ NF to NF Transfer	☐ Death *(mm/dd/yyyy):*
☐ Assisted Living Waiver Enrollment	☑ Home/Community	☐ Other:
Comments: Discharge Comment:- Patient is doing well and moved to home.		

IV. SUBMITTER INFORMATION		
Submitter Name* *(First and Last)* Arpit Patel	**Facility Name*** ADVANCE HEALTH CARE OF SCOTTSD.	**Medicaid Provider Number*** *(7-9 digits)* 2691583
Email Address* arpit.patel@parthenonglobal.com	**Telephone Number*** (440) 941-5657	**Date*** *(mm/dd/yyyy)* 02/05/2026

Instructions for submitting the form:

SECTION COMPLETED	CIRCUMSTANCE	WHERE TO SUBMIT
Section II	Fee-For-Service (FFS) individual admitted to nursing facility or individual applying for Medicaid (new Medicaid applicant)	NF shall submit the form to the PAA within their region within 10 business days
Section II	Managed Care individual admitted to nursing facility	NF shall submit the form to ODM via secure email (NFStay@medicaid.ohio.gov) or FAX to 614-466-6945 or 614-387-7661 within 10 business days
Section III	FFS or Managed Care discharge from a nursing facility	NF shall submit the form to ODM via secure email (NFStay@medicaid.ohio.gov) or FAX to 614-466-6945 or 614-387-7661 within 10 business days

CONTINUATION PAGE FOR COMMENTS

Admission Comment:-
Comments by Facility:- Client was admitted from hospital for skilled nursing.