

FAX

Date:	02/04/2026
-------	------------

Pages including cover sheet:	2
------------------------------	---

To:	
Phone	
Fax Phone	+19725329272

From:	Arpit Patel
Phone	+18884110212X701
Fax Phone	+18884110212

NOTE:

Packet Routing Fax from PG : To: +19725329272, referenced id: 704762

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* testClient	Last Name* test	Middle Initial
Medicaid Number (12 digits) 453552	Social Security Number* 123-20-0123	Date of Birth (mm/dd/yyyy) 02/04/1985
If individual does not have a Medicaid Number, has a Medicaid application been submitted? <input type="checkbox"/> Yes (provide application date) <input type="checkbox"/> No <input type="checkbox"/> Unknown		Application Date (mm/dd/yyyy)
II. FACILITY INFORMATION – ADMISSION OR NF TRANSFER		
Admission Date (mm/dd/yyyy)* 11/05/2025	Type of Admission* <input type="checkbox"/> Fee-For-Service (submit to PAA) <input type="checkbox"/> Managed Care (submit to ODM) <input checked="" type="checkbox"/> New Medicaid Applicant (submit to PAA) Plan Name:	
Comments: Comments by Facility:- TestClient Comments		
III. FACILITY INFORMATION – DISCHARGE, DEATH OR NF TRANSFER		
Date of Discharge* (mm/dd/yyyy) 11/14/2025		
Reason for Discharge* <input type="checkbox"/> Waiver Enrollment <input type="checkbox"/> NF to NF Transfer <input type="checkbox"/> Death (mm/dd/yyyy): <input checked="" type="checkbox"/> Assisted Living Waiver Enrollment <input type="checkbox"/> Home/Community <input type="checkbox"/> Other:		
Comments: Discharge Comment:- Patient Discharged		
IV. SUBMITTER INFORMATION		
Submitter Name* (First and Last) User1 Test	Facility Name* newPacketProvider	Medicaid Provider Number* (7-9 digits) 43443434
Email Address* User1.Test@testing.com	Telephone Number* (197) 025-8404	Date* (mm/dd/yyyy) 11/14/2025

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