APPENDIX E

PREADMISSION/CONTINUED STATE INPATIENT CARE TRANSMITTAL

(FORM 10A)

And INSTRUCTIONS

☐ ATTACHMENT INDICATOR

PREADMISSION/CONTINUED STAY
Inpatient Care Transmittal

FORM NUMBER
24-06-49

UTAH DEPARTMENT OF HEALTH
MEDICAL SERVICES FORM

Document No
0000000

1. Client Last Name	2. Client First Name	3. Date of Birth MM /DD /YY	4. Sex	5. Client ID Number

6. Client: Street	City	State	Zip Code	7. Client Social Security No.

8. Does Client have health insurance other than Medicaid? ☐ Yes ☐ No (A) (B)	9 If yes, give health insurance policy number	10. If client has health insurance, give insurance company Name, Address, Zip Code

11. Medicare Covered Period From To	12. Medicare ID No	13. Admission Date into Facility MM DD YY	14. TPL ☐ TPL Amount_____

15. Attending Physician Name	16. Attending Physician License Number

17. Admitting Physician Name	18. Admitting Physician License No.

19. Responsible Party and/or Next of Kin	20. Relationship	21. Telephone

22. Street Address	23. City	24. State/Zip Code

25. ICD-10-CM Code		26. Diagnosis Description	27 .Onset MM/YY	ICD-10-CM Code		Diagnosis Description	Onset MM/YY
1			/	8			/
2			/	9			/
3			/	10			/
4			/	28. ICD-10-CM Code		29. Surgical Procedure Description	30. Date MM/YY
5			/	1			/
6			/	2			/
7			/	3			/

31. Provider: Name, Address, Zip Code
Phone No.

32. Medicaid Provider No. _____

34. The PROVIDER recommends that the care/services . required by this patient to be (check one):

☐ ICF/MR-I ☐ Nursing Facility I ☐Intensive Skilled Care
☐ ICF/MR-II ☐ Nursing Facility II ☐Undetermined
☐ ICR/MR-III ☐Nursing Facility III ☐ Other _____

35, _____
Signature of Administrator or Administrative Designee Date

33. _____
Signature of Director of Nursing or Designated Charge Nurse

36. _____
Signature of QMRP (ICF/MR Facility Only) Date

(Nursing Facility Only

37. Approved ☐

STATE USE ONLY

38. Begin Date _____/_____/_____

End Date" _____/_____/_____

40. Level of Care:
☐ NF 1 ☐ NF II ☐ NF III
☐ Intensive Skilled Care ☐ ICF/MR I ☐ ICF/MR II ☐ICF/MR III

41. Denial Code ☐☐☐

42. Review I.D. ☐☐☐

39. A. Primary Diagnosis _____

B Secondary Diagnosis _____

REMARKS:

43. a _____
Signature Date MM DD YY

b. _____
Signature Date MM DD YY