Utah Department of
Health & Human Services
Integrated Healthcare

Nursing Facility Monthly Patient-Day Assessment Report

Name of Facility ______________________________ Month __________ Year ________

Current Month Patient Days **Not Subject to Patient-Day Assessment**

Medicare

Medicare HMO

Total Current Month Patient Days Not Subject to Patient Day Assessment

Current Month Patient Days Subject to Patient-Day Assessment

Medicaid - Utah

Medicaid – Non-Utah

Veterans

Private

Long Term Care - Managed Care (Medicaid Only)

Hospice - Medicaid

Hospice – Non-Medicaid

Other

Total Current Month Patient Days Subject to Patient Day Assessment

Patient Day Assessment Rate Per Day $28.15

Total Patient Day Assessment Due (Patient Days subject to Assessment X Patient Day Assessment Rate Per Day amount)

Effective for all non-Medicare bed days & admissions beginning 7/1/2020
(Begins with July 2020 numbers reported in August 2020)

FILING REQUIREMENT
THIS REPORT AND PAYMENT MUST BE RECEIVED BY DMHF ON OR BEFORE THE LAST DAY OF THE NEXT MONTH AS REQUIRED IN UAC R414-401.

Reports and payment may be mailed to:

DHHS - Division of Integrated Healthcare
Attn: Nursing Home Assessment
P.O. Box 143104
Salt Lake City, UT 84114-3104

If submitting electronic payment, email a copy of the wire transfer and this report to:
medicaidinvoicing@utah.gov

I HEREBY CERTIFY THE INFORMATION PROVIDED IN THIS REPORT IS TRUE AND COMPLETE AS PREPARED FROM THE BOOKS AND RECORDS OF THE ABOVE NURSING FACILITY. RECORDS NECESSARY TO VERIFY THE ABOVE INFORMATION SHALL BE MADE AVAILABLE TO AGENTS OF THE STATE OR FEDERAL GOVERNMENT ON DEMAND. I UNDERSTAND PAYMENTS OWING TO THE FACILITY NAMED ABOVE MAY BE WITHHELD IF THE INFORMATION REQUESTED ABOVE HAS NOT BEEN TIMELY PROVIDED.

Preparer: ____________________ ____________________ ____________________
Signature Title Date

______________________________________ ____________________
Email Address Phone Number