**Team Order: MDS, BO, Therapy, NSG, SW, RD**

**Resident Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Readmission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Resident Identifiers (Full name spelling, DOB, SSN, MBI): Medicare card = PCC Profile?**
2. **Dates of 3-Night Qualifying Stay**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Primary Payer:**

* **Medicare - # Days** **on admission: \_\_\_\_\_\_\_\_\_\_\_\_\_**
* **If ≥65 with no MCR-A, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **MCR Replacement/Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Pre-auth completed, with name/number of contact in PCC**

* **Commercial/name of insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Pre-auth completed, with name/number of contact in PCC**

1. **Secondary Payer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **LTC Medicaid Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **PP**