



**Nebraska Health Connection (NHC)
Notification of Services
Nursing Facility/Transplant**

HHS Medicaid Division - Fax Number (402) 742-2337

Name of Person Completing Form

Plan Name:

Telephone Number:

Client Information

Name

Medicaid ID Number

Date of Birth

Primary Care Physician

Telephone Number

HHS Worker Name

Telephone Number

Case Information /Case Changes

Change in Living Arrangement (NF) (If completed, Level of Care Change Section MUST be completed)

Facility Name

Address

Date of Admission

Contact Person

Phone

Level of Care Change

From Care Level

To Care Level

Effective Date of Change

Transplant Evaluation

Date of Prior Authorization Request

Date of Transplant

Date of Preparatory Treatment for Bone Marrow/Stem Cell Transplant

Facility Name/Address where transplant to be completed

For Central Office Completion

Attachments

Yes No

Verification Requested

Yes No

Status Change

Status Change

Disenrolled Other Specify

Effective Date of Change