Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Caregiver Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  **ER Visit** |  **Ambulance Pick Up** |  **Hospital Admission** |
| **Hospital Location** |  | **Date/Time of Occurrence:** |  |

|  |
| --- |
| Describe Situation: |
|  |
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|  |

I have done each of the following as instructed by Infinity of Page Home Health to ensure proper notification of changes for Insurance Claims to the State of Arizona

* **I have ensured the safety of the client**
* **I have alerted my employer Infinity of Page Home Health Care**
	+ Who\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Date:\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_
* **I have given this written notice form to Infinity of Page Home Health Care by means of**
	+ FAX
	+ MAIL
	+ DROP OFF
* **I have alerted the Case Manager on behalf of the client**
	+ Case Manager Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_

Reporting Person Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_