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

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

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

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_