

# Member Move Form

**Instructions:** Complete this form to report admission and/or discharge of a Sunshine Health LTC member to your facility. Form is due on actual date of admission or discharge date. Send completed form to [LTC\\_SSHP\\_Member\\_Info\\_Request@CENTENE.com](mailto:LTC_SSHP_Member_Info_Request@CENTENE.com).

## Member Move Form

(To Be Completed For Sunshine Health Members)

Reporting Facility Name:

Member Name:

Medicaid ID:

Admit Date:

Type of Admission:

Discharge Date:

Discharge Location:

Facility Name (if applicable):

Discharge Address:

## Instructions on how to complete the LTC Facility Member Move Form

Associated column	What to enter in the form field	Drop down defined	Example
Reporting Facility Name	Enter your facility name		ABC Nursing and Rehab of Orlando
Member Name	Enter member name		John Doe
Medicaid ID	Enter member's Medicaid number		Enter member's Medicaid number
Admit Date	Enter date member entered your facility		9/9/2019
Type of Admission	Choose one of the drop down options: Custodial or Rehab	<p><b>Custodial:</b> Member was admitted under Long Term Care as Custodial</p> <p><b>Rehab:</b> Member was admitted for Skilled/ Rehab Services</p>	Custodial
Discharge Date	Enter date member left your facility		9/9/2019
Discharge Location	Choose one of a drop down among: ALF, AMA, Behavioral Health Facility, Custodial, Home, Hospital	<p><b>ALF:</b> Member was discharged to an Assisted Living Facility</p> <p><b>AMA:</b> Member left the facility Against Medical Advice</p> <p><b>Behavioral Health:</b> Member was discharged to Behavioral Health Facility</p> <p><b>Custodial:</b> Member became Custodial at any point during their stay</p> <p><b>Home:</b> Member was discharged home</p> <p><b>Hospital:</b> Member was admitted to hospital</p> <p><b>Location Unknown:</b> Member location is unknown</p>	ALF
Facility Name/ Discharge Address	Enter name of facility (if applicable) and address	<p>If member was discharged <b>Home:</b> Enter the discharge address</p> <p>If member was discharged to a <b>Facility/ Hospital:</b> Enter name and address</p> <p>If member location is <b>Unknown:</b> Field may be left blank</p>	XYZ Assisted Living Facility of Miami 999 SW St., Miami, FL 33012