Department of Health and Mental Hygiene – Office of Health Services
REPORT OF ADMINISTRATIVE DAYS IN A NURSING FACILITY – DHMH 2129

NOTE: A separate form is to be submitted monthly. Please write legibly.

Dates of administrative days requested. From _____/_____/_____ Through _____/_____/_____

Facility name: _____ Phone: _____

Resident name: _____

Medical Assistance number: | | | | | | | | | | | | **(Note: M.A. # is 11 digits)**

Reclassified from NF to: Less than NF _____ ICF/MR _____ Effective date: _____/_____/_____

List the dates action was taken to find appropriate placement and briefly describe each.
If resident cannot be moved, physician documentation is necessary and should be attached and noted below.

Date	Actions Taken and Outcomes

Number of administrative days requested: _____

Administrator or designee: _____ _____
(Print Name) (Signature)

_____ _____
(Title) (Date)

Utilization Control Agent Certification – for UCA Use Only

UCA Representative: _____
(Please Print Name & Organization)

Days approved: _____ **Reason (if different from days requested):** _____

_____

Signature: _____ **Date:** _____