



MLTSS Facility Alert Form

Date of Notification:		
Member Information		
Member Name:		
Member ID:		
Provider Information		
Provider Name:		
Provider ID:		
IDT Meeting		
Expected Meeting Date: <small>Requires 7 day prior notification</small>		
Hospital Admission Alert / Emergency Room Alert (regardless of the primary payer)		
Admission Date:	Hospital Name:	Return to Facility Date:
Fall Alert		
Date of Fall:	Medical Attention Required (Y/N):	Reason for Fall:
Notification of Death		
Date of Action:		
Transition to Community		
Date of Action:		
Comments:		
Completed By:		
Phone Number:		

To report an incident, please fax this form to Horizon NJ Health's MLTSS Staff at **1-973-274-3864**.