

BED CHANGE REQUEST FORM

**Agency for Health Care Administration
Long Term Care Unit, MS 33, 2727 Mahan Drive, Tallahassee, FL 32308
Form must be complete to avoid a delay in processing Bed Change Request**

DATE OF REQUEST (this request must be received by AHCA 45 days before first day bed change begins - Exceptions: bed location changes {30 day advance notification required} and dual certification of whole facility - see HCFA All States Letter 22-00)_____

DATE BED CHANGE WILL BEGIN (must begin on the first day of a cost report quarter/year: Exceptions: bed location changes and dual certification of whole facility - see HCFA All States Letter 22-00 for exceptions)_____

NAME OF FACILITY_____

STREET ADDRESS_____

CITY, ZIP_____

PHONE_____FAX_____

FISCAL INTERMEDIARY_____

MAILING ADDRESS_____

CITY/STATE/ZIP_____

MEDICARE PROVIDER NUMBER_____

TOTAL NUMBER OF BEDS IN FACILITY_____

FACILITY'S FISCAL YEAR END DATE (this date is not related to your Medicare/Medicaid contract)_____

CURRENT NUMBER OF BEDS

A. TITLE 18 (MEDICARE ONLY) DO NOT INCLUDE MEDICAID BEDS IN THIS COLUMN	B. DUALY CERTIFIED 18/19 (MEDICARE AND MEDICAID BEDS COMBINED)	C. TITLE 19 (MEDICAID ONLY) DO NOT INCLUDE MEDICARE BEDS IN THIS COLUMN	D. PRIVATE OR OTHER PAY OR SOURCE (neither Medicare nor Medicaid)	=	TOTAL NUMBER OF BEDS IN FACILITY: MUST EQUAL A+B+C+D
				=	

REQUESTED CHANGE

A. TITLE 18 (MEDICARE ONLY) DO NOT INCLUDE MEDICAID BEDS IN THIS COLUMN	B. DUALY CERTIFIED 18/19 (MEDICARE AND MEDICAID BEDS COMBINED)	C. TITLE 19 (MEDICAID ONLY) DO NOT INCLUDE MEDICARE BEDS IN THIS COLUMN	D. PRIVATE OR OTHER PAY OR SOURCE (neither Medicare nor Medicaid)	=	TOTAL NUMBER OF BEDS IN FACILITY: MUST EQUAL A+B+C+D
				=	

FOR OFFICE USE ONLY

BED CHANGE APPROVED YES _____ NO _____

NUMBER OF CHANGES REQUESTED _____

SUPERVISOR SIGNATURE _____