MAP-4105 **Kentucky Department for Medicaid Services**
1/23/04

APPLICATION FOR TRANSFER TRAUMA EXEMPTION

Printed Name of Attending Physician: _____

PROVIDER INFORMATION

Name of Provider: _____ Provider # _____

Provider's Address: _____

_____

_____

RECIPIENT INFORMATION

Name of Recipient: _____MAID # (or SS#)_____

Birth Date: _____ Age: _____ Sex: _____

Date of Admission: _____ Number of Consecutive Months at Facility:_____

JUSTIFICATION WHY THIS RECIPIENT WOULD BE HARMED UPON TRANSFERRING FROM THIS NURSING FACILITY:

_____

_____

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_____

I attest that this is true and accurate information.

_____ _____

Attending Physician's Signature **Date**