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
Additional forms may be found on the LTC web site at the address below:
http://www.fdhc.state.fl.us/MCHQ/Health_Facility_Regulation/LTC/index.shtml

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_____

CURRENT NUMBER OF BEDS

A.TITLE 18 (MEDICARE ONLY) DO NOT INCLUDE MEDICAID BEDS IN THIS COLUMN	B. DUALLY 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. DUALLY 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_____

SIGNATURE

Revised, March 2018