Medicare/Skilled Nursing Facility
Patient Transaction Notice

1. Medicaid Recipient No.	2. Social Security No.	3. Medicare or RR Retirement Claim No.
4. Name of Recipient (Last, First, Middle) - Enter first two letters of last name in far left positions.		
5. Address (if known), Preadmission or Post Discharge Only		
6. DADS Vendor No.	7. Contract No.	8. Service Group
9. NPI No.		

10 - Transaction

- ☐ **1 - Admission From**
- ☐ **2 - Discharged to**
- ☐ **3 - Deceased**
- ☐ **4 - Correction**

- ☐ 1 - Hospital
- ☐ 2 - Nursing Facility
- ☐ 3 - Full Medicare Coverage
- ☐ 4 - Home
- ☐ 5 - Institution
- ☐ 6 - Other/Unknown

11. Date of Above Transaction

12. Dates of Qualifying Stay - Enter an explanation in the "Comments" section if less than 20 days of "Qualifying Stay" are entered on this form. If additional sets of dates are needed, a second Form 3619 must be completed using the same "Date of above Transaction" in order to supply the additional set(s) of dates.

12.a. Dates of Qualifying Stay

From	To

12.b. Dates of Qualifying Stay

From	To

13. Comments

15. I certify that, to the best of my knowledge, the date in Item 11 (Date of Above Transaction) is for services provided, and the date is not included in the 100% Medicare Part A reimbursement time frame.

14. State Board License No.

Signature - Administrator

Date