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: ______________________________

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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.

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Attending Physician's Signature **Date**