Department of Health
and Mental Hygiene

Medical Care Programs

Medical Care Finance
& Compliance Administration

Report of Administrative Days

1. Patient: _____ 2. Medical Assistance #: _____
3. Hospital: _____ 4. Admission Date: _____
5. Diagnosis: (Adm.) _____ (Disc.) _____
6. Date Eligible for Other Level of Care: _____ 7. Level of Care Requested: _____
8. Other reasons for Extended Stay: _____

CASE ID:

---

9. Completion of Referral:
   a. Date social worker became active in case: _____
   b. Date UCA notified by hospital of initiation of Discharge Planning: _____
      (Utilization Control Agent – Delmarva (UCA)
   c. Level of Care Received (1) Date: _____

      (2) Method (Check one) ☐ 256R ☐ 257 ☐ Phone Call

10. Placement Efforts (Use extra sheet if necessary.)

Date	Facility	Results

11. Discharge Date and Name of Facility to which Discharged: _____
12. Length of Stay: _____ 13. Total Administrative Days: _____
14. Review Coordinator Signature: _____ Date: _____

++++++++++++++++++++++++**For Utilization Control Agent (UCA) Use Only** ++++++++++++++++++++++

Dates UCA Reviewed Continuation of Administrative Days: _____

Days Approved: _____ Days Denied: _____

UCA Signature: _____ Date: _____

Report of Administrative Days

10. Placement Efforts (Use extra sheet if necessary.)

Date	Facility	Results

11. Discharge Date and Name of Facility to which Discharged: _____