REPORT OF OVERNIGHT MEDICAID OR MCO/MEDICAID PATIENTS ON LAST DAY OF THE MONTH

Hospital: _____

Contact Person: _____

Telephone #: _____

Fax #: _____

Patient Name	Date of Admission/Date of Discharge	Date of Birth	SSN #:	Medicaid I.D. #:	MCO (If Known)

Please fax this report on the first day of each month to the attention of Carolyn Peete.

Phone: 804-225-4793
Fax: 804-786-5799