Assisted Living Facility (ALF)
Monthly Encounter Log

aetna
Aetna Better Health® of Florida

This form must be completed monthly for enrollees receiving services in your Assisted Living Facility (ALF) in order to comply with Aetna Better Health of Florida (ABHFL) and Florida Agency for Health Care Administration (AHCA). Completed form can be emailed to our ALF Encounter dedicated mailbox at ALFencountersABHFL@aetna.com.

Facility Name:		NPI		TAX ID Number:	
Facility Address:		Phone:		Medicaid ID No.:	

Enrollee Name:	Enrollee ID:	Enrollee DOB:	Place of Service	Procedure Code:	Diagnosis Code:	Date (s) of Service-From:	Date (s) of Service-To:	Unit (s)= No. of Days:	Charges:
				T2030	R69				
				T2030	R69				
				T2030	R69				
				T2030	R69				
				T2030	R69				

Total Charges: $_____

Comments:_____
_____

I attest that I am an authorized manager and/or officer of the above-named Assisted Living Facility (ALF) and that the information reflected within the monthly encounter log is true, accurate and complete. All services furnished to the Aetna Better Health of Florida (ABHFL) enrollee (s) are valid. I understand and agree that the ALF shall be subject to and bound by all rules, regulations, policies, standards, and procedures under our current agreement with ABHFL and as set forth by the Agency for Health Care Administration (AHCA) and all other related regulatory parties.

Facility Signature:		Date Signed:	
Print Name:		Title:	