Once form is complete, please send to the Medical Management and Policy Department.

FAX to:
800.416.9195
Or Call to:
866.634.6468

Discharge Notification

Date of Notification: _____

Facility/Hospital Name: _____

Facility/Hospital Contact Name and Phone #: _____

Member Name: _____ Member Phone #: (_____)_____

Member ID (*including three letter alpha prefix*): _____

Diagnosis: _____

Admission Date: _____

Discharge Date: _____ Discharge Time (*if applicable*): _____

Discharge Note of Member Status at Discharge:

_____

_____

_____

Discharge Disposition (*e.g., home, skilled nursing facility, home health, PT, etc.*): _____

_____

Medications: _____

_____

_____

Comments/Concerns: _____

Date of submission: _____ Submitted by: _____

Date /Time received (For internal use only):_____