

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): _____