Hospital Discharge Form

Sender/Caller Information: ☐ Patient ☐ Hospital ☐ Provider

Name: _____ Phone: (_____)_____ Fax: (_____)_____

Does the patient have other insurance? ☐ No ☐ Yes:_____

Today's Date: _____/_____/_____ Time: _____:_____ _____

Patient Information:

Patient:_____ _____
Last First

HealthPartners Member ID # : _____ Date of Birth: ____/____/_____ ☐ Male ☐ Female

Admission Information:

Admission Date:_____/_____/_____

Discharge Date: _____/_____/_____

Disposition: ☐ Home ☐ Expired ☐ Nursing Home Transfer ☐ Other Hospital Transfer

Admission Source:

☐ ER/ED ☐ Direct ☐ Scheduled ☐ Direct Transferred From: _____

Admission Type, Bed, Unit (*mark all that applies*): ☐ Other_____

☐ Med/Surg ☐ ICU/CCU ☐ Mental Health ☐ Long Term Acute Care

☐ Pediatric ☐ Swing Bed ☐ CH ☐ Detox ☐ Inpatient Acute Rehab

☐ Maternity Delivery/DOB:_____/_____/_____ Nursery: ☐ Normal ☐ Level II ☐ Level III NICU

☐ Twins ☐ Triplets

Baby: ☐Boy ☐Girl Name: *Last*_____ *First*_____ Hospital MRN:_____

Baby: ☐Boy ☐Girl Name: *Last*_____ *First*_____ Hospital MRN:_____

Baby: ☐Boy ☐Girl Name: *Last*_____ *First*_____ Hospital MRN:_____

ICD-10 Diagnosis Code: _____

ICD-10 Procedure Code (Inpatient): _____

Provider Information:

Facility:_____ Phone: (_____)_____

Street: _____ UR Dept: (_____)_____

City:_____ _____ State:_____ Zip:_____

Facility Tax ID: _____ Provider Contact Name: _____

Attending Physician: _____ _____
Last First

Phone: (_____)_____ Fax: (_____)_____

Street:_____

City:_____ State:_____ Zip:_____

Physician Federal Tax ID: _____ or NPI #: _____