Hospital Discharge Summary Form

I: Member name_____ I.D.# _____
CM/DCM name _____ Phone # _____ Fax # _____
PCP name _____ Medical group/IPA #_____
Facility name _____ Attending physician _____

II: Date Services should end: _____

III: Elements that need to be put in place prior to discharge (*verify that the following information is documented in the record, if applicable)*

☐ Physician note reflecting readiness for discharge ☐ Discharge plan discussed with attending provider
☐ Discharge plan discussed with member/family ☐ Description of discharge plan in place
☐ Therapy notes (if applicable) ☐ Other (please be specific) _____

IV: Applicable Medicare coverage policies *(please select one)*

☐ Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting (refer to 42 Code of Federal Regulations, 411.15 (g) and (k)
☐ Medicare Managed Care policies, if applicable *(List specific managed care policies)* _____
☐ Other *(List other applicable policies)* _____

V: Fill in detailed and specific information about the patient's current medical condition and the reasons why services are no longer reasonable or necessary for this patient or are no longer covered according to Medicare or Medicare managed care coverage guidelines. **(Use full sentences, plain language and no abbreviations):**

1. You were admitted to (see facility above) on the following date _____
2. At admission you presented with the following symptoms:

3. You were diagnosed with

4. You were treated with

5. Your tests were (include results)

6. You were evaluated by

7. You are now (list current treatment plan and/or state the medical issue is resolved)

8. Your provider feels that your condition has improved and that the care you need now could safely be provided in/at

9. Your discharge plan and follow-up care includes

VI: Printed name of person completing the form _____
Signature of person completing the form _____
Phone # _____ Fax # _____