Print Form

Complete this form for all hospital discharges.
Reference the Hospital Discharge Summary Form Instructions for information on how to complete this form.

Fax completed to: 617-972-9516

I: Member Name______________________________ ID# ______________________ HMO______ PPO ______
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 member/family
- ☐ Therapy Notes (if applicable)
- ☐ Discharge plan discussed with attending physician
- ☐ Description of discharge plan in place
- ☐ 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 and plain language):*

You were admitted to (see facility above) on the following date ________________ for (list the following presenting symptoms)
____

You were diagnosed with ______________________________

You were treated with ______________________________

Your tests were ______________________________

You were evaluated by ______________________________

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

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

Your discharge plan and follow-up care includes ______________________________

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

7/2007