***Complete this form and fax to 1-888-656-2586 within one day of the member’s discharge.***

|  |  |  |
| --- | --- | --- |
| Today’s Date:       | Discharge Date:       | Person Completing Form:       |
| Facility Name:       | MIS #:       | Facility Phone Number:      |

**Member Information**

|  |  |
| --- | --- |
| Member’s Name:      | Date of Birth:       |
| Street:      | City:       |
| ZIP Code:      | Phone Number:       | Medicaid Number:      |

**Address Member Discharged to:**

|  |
| --- |
| Address Member Discharged to:     Best Phone Number to Reach Member:      |

***If member is a minor, include legal guardian name and contact number:***

|  |  |
| --- | --- |
| Guardian (1) Name:      | Guardian Phone Number:      |
| Guardian (2) Name:      | Guardian Phone Number:      |

**Discharge Summary**

|  |  |
| --- | --- |
| Discharge Status:  | Discharge Disposition/Type:  |
| *If other, describe:*       |
| Prognosis:  | Discharge Plan Discussed?  |

**Discharge Diagnosis** *(Enter ICD-10 code and description*)

|  |  |
| --- | --- |
| Code:      | Description:      |
| Code:      | Description:      |
| Code:      | Description:      |

**Medications at Discharge**

|  |  |  |
| --- | --- | --- |
| Medication | Dosage | Frequency |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

**Discharge Follow-up Appointment** (Must be within seven calendar days)

|  |  |
| --- | --- |
| Date of Follow-up Appointment:      | Level of Care:       |
| Provider Name:       |
| Provider Address:       |
| City:       | State:       | ZIP Code:       |
| Provider Phone Number:       |

|  |  |
| --- | --- |
| Date of Follow-up Appointment:       | Level of Care:       |
| Provider Name:       |
| Provider Address:       |
| City:       | State:       | ZIP Code:       |
| Provider Phone Number:       |

**Barriers to treatment** (e.g., medication adherence, housing, transportation, support system)

|  |
| --- |
|       |