

Hospital Discharge Summary Form

Complete this form for all hospital discharges. Refer to [Hospital Discharge Summary Form Instructions](#) for information on how to complete this form.

Securely email completed form to CPCT_AppealsandGrievances@CarePartnersct.com.

I: Member name _____	I.D.# _____
II: Date Services should end: _____	
III: Elements that need to be put in place prior to discharge (<i>verify that the following information is documented in the record, if applicable</i>)	
<input type="checkbox"/> Physician note reflecting readiness for discharge <input type="checkbox"/> Discharge plan discussed with member/family <input type="checkbox"/> Therapy notes (if applicable)	<input type="checkbox"/> Discharge plan discussed with attending provider <input type="checkbox"/> Description of discharge plan in place <input type="checkbox"/> Other (please be specific) _____
IV: Applicable Medicare coverage policies (<i>please select one</i>)	
<input type="checkbox"/> 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)) <input type="checkbox"/> Medicare Managed Care policies, if applicable (<i>List specific managed care policies</i>) _____ _____ <input type="checkbox"/> Other (<i>List other applicable policies</i>) _____ _____	
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 # _____