CarePartners of Connecticut

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 (*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 provider
- ☐ 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, 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 # _____

CarePartners of Connecticut Provider Services: 888.341.1508