Discharge Review Form

HealthSpring℠

Fax this completed form to 855-662-7969.

Date **Discharge date**	**Member**	**Facility**
Level of care at discharge		
Home health care provider **Phone** **Services ordered**	**Durable medical equipment provider** **Phone** **Equipment ordered**	**Outpatient therapy provider** **Phone** **Services ordered**
How will patient leave facility? ☐ Private vehicle ☐ Ambulance (prior authorization required) ☐ Public transportation	**Where will patient go after discharge from facility?** ☐ Home ☐ Assisted living facility ☐ Transition to long-term care ☐ Personal care home ☐ Home of family member or caregiver	**Name, address and phone of caregiver**
Follow-up appointments already scheduled	**Follow-up appointments that need to be scheduled**	
Additional comments		

Please attach copy of discharge medications.