Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

Utilization management patient discharge form

MEMBER INFORMATION			
Patient name:		DOB:	Age:
Address:			
Gender:	☐Male	☐Female	
Race:			
Medicaid ID#:		Authorization #:	
Language:	☐English	Other:_____	
Translator:	☐Yes	☐No	

EMERGENCY CONTACT			
Name:			
Relationship:			
Phone:		Left message: ☐Yes ☐No	
Alt. phone:		Left message: ☐Yes ☐No	

MEDICAL CONDITION
Inpatient admission dx:
Primary discharge dx:
Chief complaint (brief summary):
Surgical procedures performed during stay: ☐None
H/P:

HOME CARE SERVICES/DME NEEDS	
HCS provider name:	
Phone:	Fax:
DME provider name:	
Phone:	Fax:
Services: ☐PT ☐OT ☐Nutritionist/lactation ☐Speech ☐Behavioral health ☐HHN ☐Dialysis ☐Skilled nursing ☐Rehab	

PROVIDER INFORMATION	
Facility name:	
Facility type:	
COB: ☐Yes ☐No	ELOS: Click here to enter a date.
Phone:	Fax:
Admitting/attending physician's name:	
Phone:	Fax:
Admit date: Click here to enter a date.	Discharge date: Click here to enter a date.
Admit time:	Discharge time:

DISPOSITION	
Home/other address:	
Contact name:	Phone:
Transfer facility name:	
Address:	
Phone:	Fax:
Facility contact name:	
Date and time of contact:	

PHYSICIAN CONTACT	
Primary care physician:	
Phone:	Fax:
Address:	

ATTACHED DOCUMENTS			
☐Physician's orders	☐Treatment orders	☐DME orders	
☐Discharge summary:	☐ Wound care instructions	☐Lab reports	☐Discharge med list
☐Diagnostic images	☐Pharmacy	☐Prescriptions/EDU	☐Social/behavioral Hx
☐Home health order	☐Med. rec.	☐Rehab order	☐Consults

CARE COORDINATION	
Primary UM name: Phone: Fax:	Case manager name: Phone: Fax:
Social worker name: Phone: Fax:	Emdeon referral: Date submitted: Approved: ☐Yes ☐No

Additional notes: _____
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