

Hospital Admission/Discharge Form

Fax completed form to (952) 853-8705

Sender/Caller Information: ☐ Patient ☐ Hospital ☐ Provider

Name: _____ Phone: (____) _____ Fax: (____) _____

Does the patient have other insurance? ☐ No ☐ Yes: _____

Today's Date: ____/____/____ Time: ____:____

Patient Information:Patient: _____
Last FirstHealthPartners Member ID #: _____ Date of Birth: ____/____/____ ☐ Male ☐ Female**Admission Information:**

Admission Date: ____/____/____

Please note:***Notification of admissions are not prior authorizations**

Discharge Date: ____/____/____

***Notifications should be submitted at time of member admission**Disposition: ☐ Home ☐ Expired ☐ Nursing Home Transfer ☐ Other Hospital Transfer**Admission Source:**☐ ER/ED ☐ Direct ☐ Scheduled ☐ Direct Transferred From: _____**Admission Type, Bed, Unit (mark all that applies):**☐ Med/Surg ☐ ICU/CCU ☐ Mental Health☐ Pediatric ☐ CH ☐ Detox☐ Maternity Delivery/DOB: ____/____/____ Nursery: ☐ Normal ☐ Level II ☐ Level III NICU☐ Twins ☐ TripletsBaby: ☐ Boy ☐ Girl Name: Last _____ First _____ Hospital MRN: _____Baby: ☐ Boy ☐ Girl Name: Last _____ First _____ Hospital MRN: _____Baby: ☐ Boy ☐ Girl Name: Last _____ First _____ Hospital MRN: _____**DO NOT USE THIS FORM for Skilled Nursing, Inpatient Acute Rehab, or Long Term Acute Care admissions visit: www.healthpartners.com/provider-public/forms-for-providers/ and then look under the Prior auth tab to find the correct form and fax number.**

ICD-10 Diagnosis Code: _____

ICD-10 Procedure Code (Inpatient): _____

Provider Information:**Facility Name:** _____ Phone: (____) _____

Street: _____ Facility Tax ID: _____

City: _____ State: _____ Zip: _____

UR Phone: (____) _____ UR Fax: (____) _____

Attending Physician: _____Last First
Phone: (____) _____ Fax: (____) _____

Street: _____

City: _____ State: _____ Zip: _____

Physician Federal Tax ID: _____ or NPI #: _____

Please include admission H&P information along with this form.