TUFTS Health Plan
Medicare Preferred

SNF/HHA/CORF Discharge Summary Form

Complete this form for all SNF/HHA/CORF discharges.

Refer to the SNF/HHA/CORF Discharge Summary Form Instructions for information on how to complete this form.
Fax completed form to: 617-972-9516

I:

Member Name_____ ID# _____

CM/DCM Name _____ Phone # _____ Fax # _____

PCP Name _____ Medical Group/IPA # _____

Facility/Provider Name _____ Facility/Provider Phone # _____

Attending Physician _____

II:

Indicate type of services: ☐ SNF ☐ HHA ☐ CORF

Date skilled services should end _____

Date NOMNC issued to member/representative _____

Name of person who received NOMNC_____

III:

Elements that need to be 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 attending physician

☐ Discharge plan discussed with member/family ☐ Description of discharge plan in place

☐ Therapy Notes reflect discharge status and rationale

☐ Other (please be specific)

_____

IV:

The facts used to make this decision: **See instructions**

Fill in detailed and specific information about your 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 non-medical language and NO abbreviations):

1. You were admitted to (see facility above) on the following date _____ from _____

For short term skilled nursing/rehabilitation services, due to the medical diagnosis of

_____
_____
_____
_____
_____

2. Your level of functioning prior to admission

_____
_____
_____
_____
_____

3. You were evaluated by

_____
_____
_____
_____
_____

4. Your treatment plan included

_____
_____
_____
_____
_____

5. Your therapy goals for discharge were

_____
_____
_____
_____
_____

6. You are now (list current medical/rehab status /new level of function or describe any barriers that have prevented reaching goals)

_____
_____
_____
_____
_____

7. Your physician feels that you are medically stable at this time and no longer require skilled services. You are ready for discharge to

_____
_____
_____
_____
_____

8. Your discharge plan and follow-up care includes

_____
_____
_____
_____
_____

V:

Printed name of person completing the form

_____

Signature of person completing the form

_____

Phone # (cell or beeper)_____

Provider Relations