Clear Form

HealthPartners

# 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 First

HealthPartners Member ID # : _____ Date of Birth: ____/____/_____ ☐ Male ☐ Female

**Admission Information**:

Admission Date: _____/_____/_____

Discharge Date: _____/_____/_____

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*): ☐ Other _____

☐ Med/Surg ☐ ICU/CCU ☐ Mental Health ☐ Long Term Acute Care

☐ Pediatric ☐ Swing Bed ☐ CH ☐ Detox ☐ Inpatient Acute Rehab

☐ Maternity Delivery/DOB: _____/_____/_____ Nursery: ☐ Normal ☐ Level II ☐ Level III NICU

☐ Twins ☐ Triplets

Baby: ☐Boy ☐Girl Name: *Last*_____ *First*_____ Hospital MRN: _____

Baby: ☐Boy ☐Girl Name: *Last*_____ *First*_____ Hospital MRN: _____

Baby: ☐Boy ☐Girl Name: *Last*_____ *First*_____ Hospital MRN: _____

ICD-10 Diagnosis Code: _____

ICD-10 Procedure Code (Inpatient): _____

**Provider Information**:

***Facility***: _____ Phone: (_____)_____

Street: _____ UR Dept: (_____)_____

City: _____ State: _____ Zip: _____

Facility Tax ID: _____ Provider Contact Name: _____

***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.***

Updated 1/9/20