Inpatient Hospital Assessment Form

for Acute Care Hospitals

Complete this form and fax it to **877-218-9089**. For readmissions within 30 days, please include the discharge summary from the first admission.

Section 1 – Member Demographic Information

Member First Name ______________________

Facility Name & NPI ______________________

Member Last Name ______________________

(_____) _____ - ________
Contact Phone Number

Member ID Number ______________________

_____ /_____ /________
Date of Birth

Health Plan: ☐ Blue Medicare Advantage (PPO)
☐ Blue Medicare Advantage Comprehensive (PPO)

Section 2 – ER Admission

Section 3 – CC

Section 4 – PMH

This communication may contain confidential Protected Health Information. This information is intended only for the use of the individual or entity to which it is addressed. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is STRICTLY PROHIBITED by Federal law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Please continue on the next page.

Section 5 – Vitals

Section 6 – Imaging

Section 7 – Labs

Section 8 – On Exam

Section 9 – ER Tx

Please continue on the next page.

Section 10 – Admission Orders

Section 11 – Discharge Plan

Section 12 – Readmission Information

Is the readmission within 30 days? ☐ Yes ☐ No

If Yes, please send discharge summary from the last 48 hours of the previous admission and vital signs from the last day of admission.

Section 13 – Comments

Section 14 – Discharge (D/C) Plans

_____ / _____ / _______
D/C Date (Tentative/Actual)

____
Contact Person at Discharge

Discharge to: ______________________________

(_____) _____ - _______
Contact Phone Number at Discharge

ALOC: ☐ SNF ☐ LTC ☐ Adult foster care
☐ Assisted living ☐ Senior independent living
☐ Other

____

Section 15 – Additional Notes