Montana Adult Acute Inpatient Discharge Form
Notice of Discharge from Services

Please type or print clearly. Processing may be delayed if information submitted is illegible or incomplete.

Client Information				
CLIENT NAME:				
ADDRESS:		CITY:	STATE:	ZIP:
COUNTY:	SSN:	DOB:	MEDICAID NUMBER:	
PROVIDER NUMBER:	NPI NUMBER:	TAXONOMY:		

Provider Information		
PROVIDER NAME:		
NAME OF PERSON SUBMITTING FORM:	PHONE NUMBER:	
TODAY'S DATE (MM/DD/CCYY):	CLIENT DISCHARGED TO (I.E., HOME, ANOTHER LEVEL OF SERVICE):	
CLINICIAN/THERAPIST:		
DATE OF ADMISSION (MM/DD/CCYY):	DATE OF DISCHARGE (MM/DD/CCYY):	

Discharge Instructions/Plans

To transmit request information:
Fax: 1-800-639-8982
Phone: 1-800-770-3084