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.

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

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| 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 |
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