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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