

Out of Plan Home Health Care

Discharge Notification

Attn: Out of Plan Coordinator

Toll Free Phone Number: 1-800-891-2520

Fax: 567-661-0847



ELITE | COMMERCIAL/HMO

From (Agency Name): _____

NPI#: _____

Member Name: _____

Paramount ID #: _____

Paramount Secondary ID# _____
(If applicable)

Date of Birth _____ Authorization #: _____

Start of Care Date: _____ Discharge Date: _____

Provider Billing Tax ID# (TIN): _____

Number of actual visits provided during the home care episode:

(If billing PDGM, only need to check the service and not provide visit count)

SN _____ PT _____ OT _____ ST _____ HHA _____ MSW _____

Fall Risk Assessment at Discharge for Medicare Patients:

(Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Age 65 or older | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Decreased Functional Status | <input type="checkbox"/> Taking 4 or more medications |
| <input type="checkbox"/> Prior History of falls within last 3 months | <input type="checkbox"/> Poor or impaired vision |
| <input type="checkbox"/> Environmental Hazards observed | <input type="checkbox"/> Pain affecting level of function |
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> 3 or more co Existing diagnoses |

Total Score: _____ **SOC score:** _____

Home Care Case Manager: _____ Date: _____

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