group health Cooperative of eau claire

Request Form

Discharge Information

Patient's Name: _____ DOB: _____ ID# _____

Provider: _____ NPI: _____

Admission Date: ___/___/___ Discharge Date: ___/___/___ Discharged to: _____

***Please attach discharge summary and fax to (715) 852-5755.**

Discharge Medications:

Follow-up Appointments:

Other Pertinent Information:

The submission of supporting clinical documentation/plan of care is required with this form.