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# FAX

# Care Transition – PROVIDER Notification

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| --- | --- | --- | --- |
| Date: |  |  |  |
| To: |  | From: | **, CC/CM** |
| COMPANY: |  | COMPANY: |  |
| Fax: |  | Fax: |  |
| Phone: |  | Phone: |  |
| Subject: | **Care Transition Notification** | | |

MESSAGE:

As your patient’s/client’s care coordinator/care manager, **I was notified** on       that your

Patient/Client Name**:** DOB:

was **hospitalized/admitted** at  on

was **admitted to this SNF** on

was **seen** **for an outpatient procedure** at  on

was **discharged/returned to their usual care setting/home** on

As your patient’s/client’s care coordinator/care manager; I will be assisting the member during the transition of care process and manage activities such as:

* Support the member through the transition process.
* Provide follow-up care and coordinate needed services or equipment.
* Facilitate communication between the member and the provider.

Please contact me if you have any questions about this member’s/client’s care transition.

Thank you.

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| **Comments:** |

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