

Patient Discharge Form

Today's Date: _____

Patient's Name (one patient per form): _____

Patient's Priority Health contract ID number: _____

Patient's date of birth: _____

Date of notification of discharge to member: _____

Reason for discharge: _____

Practice or provider's name: _____

Signature of provider or office manager: _____

Mail to:

Priority Health
Attn: PCP Discharge MS 1105
1231 East Beltline NE
Grand Rapids, MI 49525-4501

OR

Fax to:

Attention: PCP Discharge
Fax: 616 975-8828