**FAX-CARE TRANSITION NOTIFICATION**

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| --- | --- | --- | --- |
| Date: |        |  |  |
| To: |        | From: |       |
| Company:  |        | COMPANY: |       |
| Fax: |        | Fax: |       |
| Phone: |        | Phone: |       |
| Subject: |  **Care Transition Notification** |

As your patient’s Care Coordinator, I was notified on       that your patient:

Name:       DOB:

[ ]  Was hospitalized/admitted to       on      .

[ ]  Returned to their usual care setting/home on      .

As your patient’s Care Coordinator, I will be assisting the member during the transition of care process and manage activities such as:

* Support the member through the transition process.
* Coordinate follow-up care, needed services, or equipment.
* Facilitate communication between the member and their providers.

Please contact me if you have any questions about this patient’s care transition.

Thank you.

Comments:

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