**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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