UNICARE
An Anthem Company

Form B:
Patient Discharge Care Notification Form

Date: _____

Patient Name	ID #
Date of Transplant	Type of Transplant
UniCare CME Dates	to
Institution	Date of Discharge

Hospital:

_____

_____

(Signature) (Signature)

_____

_____

(Print Name) (Print Name)

_____

_____

(Title) (Title)

_____

_____

(Date) (Date)

After completing form: Fax one copy to UniCare's Transplant Coordinator at 800-848-3623. Keep one copy for your records.