

Behavioral Health Discharge Note

Please fax this form to 1-877-434-7578 within one business day of discharge.

Today's Date:								
Contact Information								
Member name:		Member ID /reference number:		Men	nber date	of birth:		
Member address:				Member phone number:				
Name of facility:				Facility NPI/Anthem provider number:				
Date of discharge:	Discharge address:							
Discharge phone number:	Other contact information (e.g., mobile phone, family member or guardian)?							
Was this discharge Against Medical Advice (AMA)? Yes No						No 🗌		
Was discharge information sent to the PCP?				Yes No No				
Was discharge plan discussed with member?				Yes No No				
If required for a minor, was informed consent for psychotherapeutic medication completed and given to parent/guardian? Yes No								
Were any of the following included in the discharge plan?								
Check all that apply. Skilled nursing facility			Y	es	No	Accepted	Refused	
Assisted living facility								
•								
Targeted case management								
Intensive case management								
Therapeutic behavioral onsite services								
Day treatment								
Other (specify):								

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Discharge Diagnosis (All five Axes)							
Axis I:							
Axis II:							
Axis III:							
Axis IV:							
Axis V (Global assessment of functioning):							
Discharge Medications (Include medications and doses for all conditions.)							
Are these medications on the formulary or do they require precertification? Yes No							
Has precertification been received if needed?	Yes No No						
Risk Assessment (If yes, explain.)							
Was the member stable at discharge? (No risk for suicide/homicide/psychosis)							
Discharge Appointment (Must be within seven days)							
Provider name:	Provider contract number:						
Tax ID number:	Is this an in-network provider? Yes No No						
Date of appointment:	Time of appointment:						
Describe any barriers to attending this appointment:							
Submitted by:	Phone number:						