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:	Member 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 ☐
Was discharge information sent to the PCP?	Yes ☐	No ☐
Was discharge plan discussed with member?	Yes ☐	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.	**Yes**	**No**	**Accepted**	**Refused**
Skilled nursing facility				
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 ☐
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 ☐
Date of appointment:	Time of appointment:
Describe any barriers to attending this appointment:	
Submitted by:	**Phone number:**