Inpatient Follow-up Form

TUFTS Health Plan
www.tuftshealthplan.com/providers
Provider Services - 888-884-2404

Tufts Health Plan Clinical Services – Mental Health Department
Fax: (617) 972-9442 Phone: (888) 766-9818

Facility:	Date:
Patient Name:	Tufts Health Plan Member ID #:
Date of Admission:	Date of Discharge:
Primary Discharge Diagnosis (only one diagnosis):	
Secondary Discharge Diagnosis (if applicable):	

After Care Plan	Provider Name	Phone Number	Appointment Date
Psychopharm:	_____	_____	_____
Psychotherapy:	_____	_____	_____
PH, IOP, ART:	_____	_____	_____

PCP or Medical Case Manager must be notified for authorization before SNF transfer or VNA referral

SNF:	_____	_____	_____
VNA (Psych Nurse or Social Worker):	_____	_____	_____

- If an appointment time is not listed please explain
- Primary Care Physician (PCP) Follow-up does not count as a follow-up Mental Health Provider

Did you notify the PCP of this member's admission? Yes ☐ No ☐ Date Notified:_____

For members transferred to a SNF or with a VNA referral
Date of Notification of PCP or Medical Case Manager: _____

Facility Discharge Planner Name:	Facility Discharge Planner Phone #: