

## Behavioral Health Discharge Note

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

Today's date:				
<b>Contact information</b>				
Member name:	Member ID /reference number:	Member date of birth:		
Member address:		Member phone number:		
Name of facility:		Facility NPI:		
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 <input type="checkbox"/>	No <input type="checkbox"/>
Was discharge information sent to the PCP?				
			Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was the discharge plan discussed with the member?				
			Yes <input type="checkbox"/>	No <input type="checkbox"/>
If required for a minor, was informed consent for psychotherapeutic medication completed and given to the parent or guardian?				
			Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Were any of the following included in the discharge plan?</b> Check all that apply.	<b>Yes</b>	<b>No</b>	<b>Accepted</b>	<b>Refused</b>
Skilled nursing facility				
Assisted living facility				
Targeted case management				
Intensive case management				
Therapeutic behavioral onsite services				
Day treatment				
Other (specify):				

<https://mediproviders.anthem.com/ky>

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<b>Discharge diagnosis (All five Axes)</b>
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V (Global assessment of functioning):

<b>Discharge medications (Include medications and doses for all conditions.)</b>	
Are these medications on the formulary or do they require precertification?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has precertification been received if needed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Risk assessment (If yes, explain.)</b>	
Was the member stable at discharge? (No risk for suicide/homicide/psychosis)	
<b>Discharge appointment (Must be within seven days)</b>	
Provider name:	Provider contract number:
Tax ID number:	Is this an in-network provider? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of appointment:	Time of appointment:
Describe any barriers to attending this appointment:	
<b>Submitted by:</b>	<b>Phone number:</b>