Healthy Blue

Medicaid Managed Care

Behavioral Health Discharge Note

Submit this form using our preferred method via the provider website at **https://providers.healthybluela.com** or fax to **1-844-432-6027** 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/Healthy Blue provider number:
Date of discharge:	Discharge address:	
Discharge phone number:	Other contact information (for example, mobile phone, family member or guardian):	

Circle Yes or No.		
Was this discharge against medical advice?	☐ 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				
Residential treatment				
Intensive case management				
Intensive outpatient services (in other words, ACT, psychosocial rehabilitation)				
Therapeutic behavioral on-site services				
Day treatment				
Other (specify)				

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DSM-5/ICD-10 discharge diagnoses (psychiatric, chemical dependency and medical)	
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 or 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: