Amerigroup
District of Columbia

https://providers.amerigroup.com/DC

Behavioral Health Discharge Note

This form is for inpatient mental health and chemical dependency, chemical dependency residential treatment, psychiatric medical institution for children, partial hospitalization program, or intensive outpatient program.

Please submit this form electronically using our preferred method by logging onto Availity from the Amerigroup District of Columbia, Inc. provider website at https://providers.amerigroup.com/DC. This form can also be submitted via fax to 1-877-434-7578 on the last authorized day.

Today's date:		
Contact information		
Member name:		
Member address:		
Member ID/reference #:	Member DOB:	Member phone number:
Name of facility:		Facility NPI/provider number:
Date of discharge:	Discharge phone #:	
Discharge address:		
Other contact information (mobile phone #, family member or guardian):		
Was this discharge against medical advice?		☐ Yes ☐ No
Was discharge information sent to the PCP/psychiatrist?		☐ 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 the 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	☐	☐	☐	☐
Day treatment	☐	☐	☐	☐
Intensive psychiatric rehabilitation	☐	☐	☐	☐
Community support services	☐	☐	☐	☐
Assertive community treatment	☐	☐	☐	☐
Peer support services	☐	☐	☐	☐
Other (behavioral health intervention services [BHIS], mental health [MH] therapy, medical management, high anxiety-related behavior [HAB], waiver services, HH, Alcoholics Anonymous [AA] or Narcotics Anonymous [NA]):	☐	☐	☐	☐

ICD-10-CM discharge diagnoses — psychiatric, chemical dependency and medical:	
Discharge medications — Include medications and doses for all conditions:	
Are these medications on the formulary?	☐ Yes ☐ No
Do these medications require precertification?	☐ Yes ☐ No
Is receipt of precertification needed?	☐ Yes ☐ No
Risk assessment — If yes, explain.	
Was the member stable at discharge or at no risk for suicide/homicide/psychosis?	

Discharge appointment — Must be within seven days of discharge.	
Provider name:	Provider contract #:
Tax ID #:	Is this an in-network provider? ☐ Yes ☐ No
Date of appointment:	Time of appointment:
Describe any barriers to attending this appointment:	
Submitted by:	**Phone #:**
Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.	