Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

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/Amerigroup* provider number:
Date of discharge:	Discharge address:	

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 ☐
Are there any gaps in care or needs that should be addressed post discharge? (housing, transportation, food, medical illness, etc.) If yes, please list:	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):				

Discharge diagnosis (all five axes)
Axis I:
Axis II:
Axis III:
Axis IV:
Axis V (global assessment of functioning):

**Amerigroup members in the Medicaid Rural Service Area and the STAR Kids Program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.*

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 contact 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:**