Amerigroup RealSolutions in healthcare

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Transitions program appointment/encounter worksheet

Patient name: _____ Member ID: _____

Patient address: _____

Patient phone #: _____

Patient DSM or ICD diagnosis _____

Facility name: _____ Discharge date: _____

Facility contact name: _____

Phone number: _____ Fax: _____

Please indicate barriers preventing an appointment within 7 days (check all that apply):

- ☐ No prior relationship with an outpatient provider
- ☐ Frequent readmissions
- ☐ Transportation
- ☐ Appointment availability (outpatient provider not available in 7 days)
- ☐ Member compliance
- ☐ Other - please describe: _____

Date of next appointment: _____ Provider: _____

I certify that one or more of the following items were addressed with the member during the transition appointment: identify/discuss any issues/anxieties or concerns about transitioning home; identify/discuss a plan for medication adherence; develop emergency plan and identify symptoms requiring immediate treatment; support engagement with community provider.

_____ _____

Requesting clinician (print name) Licensure

_____

Signature

_____ _____

Date Time

42 Rev Code	Description	HCPCS
0513	Clinic, outpatient services	T1015

Fax form to: Attn: Transition Program at 1-877-434-7578

Important Note: You are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating or have 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.

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