Behavioral Health Discharge Note

(Inpatient [MH and CD], CD residential treatment, PMIC, PHP or IOP)

Please submit using our preferred electronic method via the provider website at **https://provider.amerigroup.com/DC** on the last authorized day.

Today's date:	
Contact information:	
Enrollee name:	
Enrollee ID/reference number:	
Enrollee phone number:	Date of birth:
Enrollee address:	
Name of facility:	
Facility NPI/provider number:	Date of discharge:
Other contact information (Mobile phone, family enrollee, 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 enrollee?	Yes ☐ No☐
If required for 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	☐	☐	☐	☐
Day treatment	☐	☐	☐	☐
Intensive psychiatric rehabilitation	☐	☐	☐	☐
Community support services	☐	☐	☐	☐
Peer support services	☐	☐	☐	☐
Other (BHIS, MH therapy, med management, HAB, waiver services, HH, AA, NA):	☐	☐	☐	☐

IDC-10 discharge diagnosis (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 enrollee 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 the patient attending this appointment:	
Submitted by:	**Phone:**