Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

Behavioral Health Discharge Form

Please submit this form on the provider website, https://providers.amerigroup.com/GA, within one business day of discharge.

Today's date:	
Contact information	
Member name:	
Member DOB:	
Member identification number:	
Member address:	
Other contact information (e.g., mobile phone, family member or guardian)?	
Does Amerigroup Community Care have permission to use all listed contact numbers for further discussion about the member's health care? ☐Yes ☐No	
PCP:	
PCP phone number:	
Name of facility:	
Facility NPI/Amerigroup provider number:	
Date of admission:	Admission time:
Date of discharge:	Discharge time:
Discharge address:	
Discharge phone number:	
Care coordination	
Primary utilization management (UM) name:	
UM phone number:	UM fax:
Case manager:	
Case manager phone number:	Case manager fax:
Social worker:	
Social worker phone number:	Social worker fax:
Discharge information	
Was this discharge against medical advice? ☐ Yes ☐ No	
Was discharge information sent to the member's PCP? ☐ Yes ☐ No	
Was a discharge plan discussed with the member? ☐ Yes ☐ No	
If required for a minor, was informed consent for psychotherapeutic medication completed and given to the parent or guardian? ☐ Yes ☐ No ☐ N/A	

Discharge information (continued)

Were any of the following included in the discharge plan?

Check all that apply.

Skilled nursing facility	☐ Yes	☐ No	☐ Accepted	☐ Refused
Assisted living facility	☐ Yes	☐ No	☐ Accepted	☐ Refused
Day treatment	☐ Yes	☐ No	☐ Accepted	☐ Refused
Intensive psychiatric rehabilitation	☐ Yes	☐ No	☐ Accepted	☐ Refused
Community support services	☐ Yes	☐ No	☐ Accepted	☐ Refused
Assertive community treatment	☐ Yes	☐ No	☐ Accepted	☐ Refused
Peer support services	☐ Yes	☐ No	☐ Accepted	☐ Refused
Other (specify):_____ _____	☐ Yes	☐ No	☐ Accepted	☐ Refused

ICD-10 discharge diagnoses

Please list all ICD-10 diagnoses at discharge (psychiatric, chemical dependency and medical).

_____

_____

_____

_____

Discharge medications

Please list all medications and their doses.

_____

_____

_____

_____

Are these medications on the formulary, or do they require preauthorization? ☐ Yes ☐ No

If needed, has preauthorization been received? ☐ Yes ☐ No ☐ N/A

Risk assessment

Was the member stable (no risk for suicide, homicide or psychosis) at discharge? ☐ Yes ☐ No

If no, please explain: _____

_____

_____

_____

Discharge appointment (must be within seven days)
Provider name:
Provider contract number:
TIN:
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: