AmeriHealth Caritas Delaware

Behavioral Health Discharge Note

(Inpatient behavioral health)

Submit to: Behavioral Health Utilization Management (BH UM)
Fax: 1-877-234-4273
For assistance, please call: 1-855-301-5512

Please fax this form to BH UM department within 24 hours of discharge.

Important note: You are not permitted to use or disclose protected health information about individuals who you are not currently 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.

Today's date:

CONTACT INFORMATION

Member name:		
Member ID number:	Member date of birth:	Member phone number:
Member address:		
Name of facility:		
Facility NPI number:	Date of admit:	Date of discharge:
Location discharged to (e.g., home or shelter):		Discharge phone number:
Discharge address:		
If a minor or dependent adult, list name and contact information and any other pertinent contact information:		

ICD-10 DISCHARGE DIAGNOSES (psychiatric, chemical dependency, and medical)

Was this discharge against medical advice (AMA)? ☐ Yes ☐ No
Was discharge information sent to the primary care provider or psychiatrist? ☐ Yes ☐ No
Was the discharge plan discussed with the member? ☐ Yes ☐ No
If required for a minor or dependent adult, was informed consent for psychotherapeutic medication completed and given to the parent or guardian? ☐ Yes ☐ No

Were any of the following included in the discharge plan? Complete all that apply.	
Mental health therapy, intensive outpatient therapies, or medical management?)? ☐ Yes ☐ No ☐Refused	
Provider name:	Phone number:
Address:	
Contact person if known:	

COLLABORATION OF NEEDS

Please indicate if collaboration is needed with any of the below, and include contact name and phone number:

Adult protective agency: ☐ Yes ☐ No	Contact information:
Jail, prison, or court system: ☐ Yes ☐ No	Contact information:
Long-term services and supports (waiver programs): ☐ Yes ☐ No	Contact information:
Nursing or nursing home facility: ☐ Yes ☐ No	Contact information:
Residential program: ☐ Yes ☐ No	Contact information:
PROMISE program: ☐ Yes ☐ No	Contact information:
Other: ☐ Yes ☐ No	Contact information:

LIST DISCHARGE MEDICATIONS (INCLUDE ALL MEDICATIONS). **Please provide the dose, frequency, and condition for which the medication is prescribed.**
Are these medications on the formulary or do they require precertification? ☐ Yes ☐ No
Has precertification been received if needed? ☐ Yes ☐ No

DESCRIBE RISK ASSESSMENT (if there has been no risk assessment, please explain).
Was the member stable at discharge, with no risk for suicide, homicide, or psychosis)? ☐ Yes ☐ No

AFTERCARE APPOINTMENTS	
Provider name(s) (clinician and facility):	
Provider contact number(s):	
Appointment date(s):	Appointment time(s):
If no aftercare within seven calendar days, please explain:	

ARE ANY OTHER PROVIDERS INVOLVED IN THE AFTERCARE PLAN? IF YES, PLEASE LIST THEM BELOW, WITH CONTACT INFORMATION:
Name of the person submitting form:
Phone number of the person submitting form: