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https://providers.amerigroup.com/DC

Behavioral Health Discharge Note

This form is for inpatient (MH and CD), CD residential treatment, PMIC, PHP or IOP.

Please submit via the provider website at https://providers.amerigroup.com/DC or fax to 1-877-434-7578 by the final authorized day.

Today's date:		
Contact information		
Member name:	Member ID/reference #:	Member DOB:
Member address:		Member phone number:
Name of facility:		Facility NPI/provider number:
Date of discharge:	Discharge address:	
Discharge phone #:	Other contact information (mobile phone #, family member 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 member?		Yes ☐ No ☐
If required for a minor, was informed consent for psychotherapeutic medication completed and given to the 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				
Assertive community treatment				
Peer support services				
Other (BHIS, MH therapy, medical management, HAB, waiver services, HH, AA or NA):				

ICD-10 discharge diagnoses (psychiatric, chemical dependency and medical):	
Discharge medications (Include medications and doses for all conditions.):	
Are these medications on the formulary?	Yes ☐ No ☐
Do these medications require precertification?	Yes ☐ No ☐
Is receipt of precertification needed?	Yes ☐ No ☐
Risk assessment (If yes, explain.)	
Was the member stable at discharge or at no risk for suicide/homicide/psychosis?	
Discharge appointment (must be within seven days)	
Provider name:	Provider contract #:
Tax ID #:	Is this an in-network provider? Yes ☐ No ☐
Date of appointment:	Time of appointment:
Describe any barriers to attending this appointment:	
Submitted by:	**Phone #:**