



Behavioral health discharge note

(Inpatient (MH and CD), CD Residential treatment, PMIC, PHP or IOP)

Please submit via the provider portal at providers.amerigroup.com/ia
or fax to 1-877-434-7578 on the last authorized day.

Today's date:					
Contact information					
Member name:		Member ID# /reference number:		Member date of birth:	
Member address:			Member phone number:		
Name of facility:			Facility NPI/Amerigroup provider number:		
Date of discharge:		Discharge address:			
Discharge phone number:		Other contact information (mobile phone, family member or guardian)?			
Was this discharge against medical advice (AMA)?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was discharge information sent to the PCP/psychiatrist?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was discharge plan discussed with member?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
If required for a minor, was informed consent for psychotherapeutic medication completed and given to parent/guardian?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
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, med management, HAB, Waiver services, HH, AA, 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 or do they require precertification?	Yes	No
Has precertification been received if needed?	Yes	No
Risk assessment (If yes, explain.)		
Was the member stable at discharge? (no risk for suicide/homicide/psychosis)		
Discharge appointment (must be within seven days)		
Provider name:	Provider contract number:	
Tax ID number:	Is this an in-network provider?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of appointment:	Time of appointment:	
Describe any barriers to attending this appointment:		
Submitted by:	Phone:	

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.