Amerigroup RealSolutions in healthcare

KanCare

Behavioral Health Discharge Note

Please fax this form to 1-877-434-7578 within one business day of discharge.
Should more space be needed, please attach additional pages.

Today's date:	
Member information	
ID/reference number:	DOB:
Name:	
Phone:	
Address:	
Other contact information? (e.g., mobile phone, family member or guardian)	
Facility information	
Name:	
Address:	
Phone number:	
Facility NPI/Amerigroup Kansas, Inc. provider number:	
Discharge information	
Date of discharge:	
Was this discharge against medical advice?	Yes ☐ No ☐
Was discharge information sent to the PCP?	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 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	☐	☐	☐	☐
Targeted case management	☐	☐	☐	☐
Outpatient behavioral health services	☐	☐	☐	☐
Community-based/rehabilitation services	☐	☐	☐	☐
Residential treatment	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐

DSM-5/ICD-10 discharge diagnosis
(Psychiatric, chemical dependency and medical)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Discharge medications
(Include medications and doses for all conditions.)

_____
_____
_____
_____

Are these medications on the formulary?	Yes ☐	No ☐
If precertification is required, has it been received?	Yes ☐	No ☐

Risk assessment
(If yes, explain.)

Was the member stable at discharge? (No imminent risk for suicide/homicide/psychosis)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Discharge appointment
(Must be within seven days)

Provider name:	
Provider agency:	
Provider contact number:	
Tax ID number:	Is this an in-network provider? Yes ☐ No ☐
Date of appointment:	Time of appointment:
Describe any barriers to attending this appointment:	

Rapid/frequent readmission

Has member discharged from in-patient (IP) psych or resident treatment center (RTC) psych level of care within the past 30 days?	Yes ☐ No ☐
Does member have a prior history of admission(s) to IP psych or RTC psych level of care?	Yes ☐ No ☐

If the answer to either question above is yes, please provide readmission prevention plan below:

_____
_____
_____
_____
_____
_____
_____
_____

Submitted by:	**Phone number:**