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Behavioral Health Discharge Note

Please submit this form electronically using our preferred method at https://providers.amerigroup.com/NJ. You may also submit via fax to 1-877-434-7578. Please submit within one business day of discharge. Date: _____

Contact information		
Member name:	Member ID/reference number:	Member DOB:
Member address:	Member phone:	
Name of facility:	Facility NPI/Amerigroup Community Care provider number:	
Date of discharge:	Discharge address:	
Discharge phone:	Other contact information (e.g., mobile phone, family member or guardian):	

Was this discharge against medical advice? ☐ Yes ☐ No
Was this discharge information sent to the PCP? ☐ Yes ☐ No
Was this 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/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				
PACT				
Intensive case management				
Substance use disorder treatment (please specify level of care)				
Partial hospitalization/partial care				
Other (specify)				

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not 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.

Discharge diagnosis (all five axes)	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V (global assessment of functioning):	
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	
Was the member stable at discharge (no risk for suicide/homicide/psychosis)? If yes, 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:	Appointment time:
Describe any barriers to attending this appointment:	
Submitted by:	Phone: