Anthem

Behavioral Health Discharge Note

This communication applies to the Medicaid and Medicare Advantage programs in Kentucky.

Please submit this form electronically using our preferred method at **http://availity.com**.* If you prefer to fax, you may send to:

- Medicaid: **888-881-6272**
- Medicare Advantage: **844-430-1702**

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:			
Date of discharge:		Discharge phone number:	
Discharge address:			
Other contact information (e.g., mobile phone, family member or guardian)?			

Was this discharge against medical advice (AMA)?	Yes ☐	No ☐
Was discharge information sent to the PCP?	Yes ☐	No ☐
Was the 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 or 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	◯	◯	◯	◯
Intensive case management	◯	◯	◯	◯
Therapeutic behavioral onsite services	◯	◯	◯	◯
Day treatment	◯	◯	◯	◯
Other (specify):	◯	◯	◯	◯

* Availity, LLC is an independent company providing administrative support services on behalf of Anthem Blue Cross and Blue Shield.

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?	
Has precertification been received if needed?	
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:			
Tax ID number:			
Provider contact number:			
Is this an in-network provider? Yes ☐ No ☐			
Date of appointment:		Time of appointment:	
Describe any barriers to the patient attending this appointment:			
Submitted by:		**Phone number:**	