ambetter. FROM nh healthy families

SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE 1.844.265.1278
FAX 1.866.535.6974

BEHAVIORAL HEALTH DISCHARGE CONSULTATION DOCUMENTATION

Please complete all information requested on this form.

Member Name: _____ DOB: _____

Member ID#: _____ Parent/Guardian: _____

Address: _____

Phone: _____ Best time to reach member/parent/guardian: _____

Emergency and/or Additional Point of Contact: _____ Phone: _____

Outpatient Therapist: _____ Phone: _____

Date of next appointment: _____ Case Manager (if applicable): _____ Phone: _____

Psychiatrist: _____ Phone: _____ Date of next appointment: _____

Does the member have medication to last until this follow up? ☐ Yes ☐ No

Other follow-up appointments: _____

Name/Type of Provider: Phone: _____ Date of next appointment: _____

Did member attend a 513/510 (Bridge) appt. during the discharge process? ☐ Yes ☐ No

If yes, name of staff conducting the 513/510: _____

Date of the 513/510: _____ Time of the 513/510: _____

All appointments following a discharge are required to be set within seven calendar days with a licensed behavioral clinician. Any appointments outside this time frame will need to be reported to Ambetter to allow for assistance with the appropriate level of follow-up.

Medical Provider/PCP: _____ Phone: _____

DISCHARGE DIAGNOSIS:

Primary (Required) _____ Secondary _____

Tertiary _____ Additional _____

Additional _____

Medication at discharge: _____

Discharge Disposition/Where will member be staying after discharge?

_____ _____

Signature of Facility Staff Signature of Member/Guardian

_____ _____

Date of Admission/Discharge Time of Discharge

_____

Facility Fax Number

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