Clinical Services

Behavioral Health Utilization Management

Fax to: 1-877-650-6112

Discharge Form

Submission Instructions:

PLEASE ENSURE THAT ALL SECTIONS OF THE FORM ARE COMPLETE AND LEGIBLE.

Case #:	Member ID:	Discharge Date:

Section 1 Member Information	
Member Name:	Date of Birth:
Address: (No., Street, City, State, Zip)	Phone Number:
Parent/Guardian Name: (if applicable)	Phone Number:
Discharge Diagnosis:	

Section 2 Discharge Destination

Section 3 Follow-Up Appointments
Please include dates/times, provider address and contact information

Section 4 Medications