HIGHMARK
WESTERN NEW YORK

fax

TO:	**Behavioral Health UM/ATTN:**	FROM:	
FAX:	1-833-581-1866	PAGES:	
PHONE:		DATE:	
RE:	Discharge Summary	CC:	

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

Discharge Summary
Fax to: 1-833-581-1866

Discharge Details:

Facility Name_____ Facility ID_____

Facility Contact Name/Number_____

Member Name_____ Member ID_____

Discharge Date_____

Discharge Destination_____

Follow-Up Appointment:

- Location_____
- Date/Time of Appointment_____
- Contact Number_____

Additional Appointments (Optional):_____

Medications at Discharge_____

Diagnosis Code Version: ICD 10 Diagnosis Code(s)_____

Member/Guardian Contact Number_____

Step Down Information if member is stepping down to PHP/IOP Level of care:

Program Name/Location_____**Physician/Contact Number**_____
Level of Care_____**Hours/Day, Days/Week of Program**_____
Clinical Rationale (include reason for step down, symptoms, medications, treatment and discharge plan):