



Behavioral Health Discharge Notification Form

Please Fax Completed Form To: 1-888-245-2027

Behavioral Health Department: 1-800-685-5209

Member Name:	Member ID Number:
Member Phone Number:	Member Date of Birth:
Admitting Facility:	Admitting Facility Contact/ Phone Number:
Date of Admission:	Date of Discharge:

Discharge Diagnosis (Include Comorbid)

MEDICATION			
Medication	Dosage	Frequency	Address Member Discharged To:
			Type of Housing: <input type="checkbox"/> Home <input type="checkbox"/> Shelter/Mission <input type="checkbox"/> PCH/SNF <input type="checkbox"/> Homeless <input type="checkbox"/> Other: <i>(please specify)</i>

Aftercare/Discharge Plan				
Provider Name	Type of Service	Phone Number	Date	Time

Mental Status at Discharge