



## DISCHARGE CONSULTATION DOCUMENTATION

Please complete all information requested on this form.

**SUBMIT TO:**

**Utilization Management Department**

12515-8 Research Blvd., Suite 400

Austin, Texas 78759

PHONE 1.877.687.1182

FAX 1.866.535.6974

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 510 (Bridge) appt. during the discharge process? ☐ Yes ☐ No

If yes, name of staff conducting the 510: \_\_\_\_\_

Date of the 510: \_\_\_\_\_ Time of the 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