BlueCross BlueShield of North Carolina MEDICARE

# *Behavioral Health Discharge Note*

Please note, this form applies to Healthy Blue + Medicare[SM] (HMO D-SNP) offered by Blue Cross and Blue Shield of North Carolina.

Please submit this form electronically at **https://www.availity.com**.This can also be submitted via fax to **1-844-430-1702**.

| **Member Information** | | | |
|---|---|---|---|
| Member name: | | | |
| Member address: | | | |
| Member ID/reference: | | | |
| Member phone number: | | Member DOB: | |
| **Facility and Provider Information** | | | |
| Name of facility: | | Facility NPI/provider number: | |
| Date of discharge: | | Discharge address: | |
| Discharge phone number: | | Other contact information (mobile phone, family member or guardian): | |
| Was this discharge against medical advice? | | | ☐ Yes ☐ No |
| Was discharge information sent to the PCP? | | | ☐ Yes ☐ No |
| Was discharge plan discussed with member? | | | ☐ Yes ☐ No |
| If required for a minor, was informed consent for psychotherapeutic medication completed and given to parent/guardian? | | | ☐ Yes ☐ No |

Note: Availity is an independent company providing administrative support services for Healthy Blue + Medicare providers on behalf of Blue Cross and Blue Shield of North Carolina.

**https://www.bluecrossnc.com/provider-home**

| **Were any of the following included in the discharge plan?** Check all that apply. | **Accepted** | **Refused** |
|---|---|---|
| Skilled nursing facility ☐ Yes ☐ No | | |
| Assisted living facility ☐ Yes ☐ No | | |
| Targeted case management ☐ Yes ☐ No | | |
| Intensive case management ☐ Yes ☐ No | | |
| Therapeutic behavioral onsite services ☐ Yes ☐ No | | |
| Day treatment ☐ Yes ☐ No | | |
| Other (specify) ☐ Yes ☐ No | | |

| **Discharge Diagnoses** (This includes behavioral and medical health.) |
|---|
| |

| **Discharge Medications** (Include medications and doses for all conditions.) |
|---|
| |
| Are these medications on the formulary? ☐ Yes ☐ No |
| Has precertification been received, if needed? ☐ Yes ☐ No |

| **Risk Assessment** |
|---|
| Was the member stable at discharge? (No risk for suicide/homicide/psychosis) |

| **Discharge Appointment** (Must be within seven days of discharge.) | |
|---|---|
| Provider name: | |
| Provider address: | |
| Is this an in-network provider? ☐ Yes ☐ No | Provider phone: |
| Date of appointment: | Time of appointment: |
| Describe any barriers to attending this appointment: | |

| **Submitter Information:** | |
|---|---|
| Submitted by: | |
| Phone: | Date: |

**Important note:** You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.