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		
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Section 4 Medications		

Last Updated 10/05/2022