



**DISCHARGE CONSULTATION DOCUMENTATION**  
Please complete all information requested on this form. Fax to 1.866.535.6974

**DISCHARGE CONSULTATION INFORMATION**

Member Name \_\_\_\_\_ Member Phone: \_\_\_\_\_  
Member DOB \_\_\_\_\_ Parent / Guardian Name: \_\_\_\_\_  
Member ID # \_\_\_\_\_ Best Time to Reach Member/Parent/Guardian: \_\_\_\_\_  
Member Address \_\_\_\_\_ UM Name: \_\_\_\_\_  
Facility Name: \_\_\_\_\_ Emergency/Other Contact: \_\_\_\_\_  
Facility Fax Number: \_\_\_\_\_

Outpatient Therapist \_\_\_\_\_ Psychiatrist \_\_\_\_\_  
Outpatient Therapist Phone \_\_\_\_\_ Psychiatrist Phone \_\_\_\_\_  
Date of next appointment \_\_\_\_\_ Date of next appointment \_\_\_\_\_  
Case Manager (if applicable) \_\_\_\_\_  
Case Manager Phone \_\_\_\_\_ 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 513 (Bridge appt. during the discharge process? Yes  No   
If yes, name of staff conducting the 513: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of the 513: \_\_\_\_\_ Time of the 513: \_\_\_\_\_

**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 the healthplan to allow for assistance with the appropriate level of follow-up.**

Medical Provider/PCP \_\_\_\_\_ Phone \_\_\_\_\_

My signature below certifies that I have agreed to release the information contained here to my PCP and behavioral health providers. My consent is voluntary, can be revoked in writing at any time, and will be used to assist with providing referrals, resources and support related to substance abuse treatment.

**Current ICD Diagnosis**

Primary \_\_\_\_\_  
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

SUBMIT TO  
**Utilization Management Department**  
12515-8 Research Blvd., Suite 400  
Austin, Texas 78759  
PHONE 1.877.647.4848 | FAX 1.866.535.6974

1099 N. Meridian Street, Suite 400 • Indianapolis, IN 46204 • 1-877-647-4848 • mhsindiana.com  
Members with speech or hearing disabilities call 1-800-743-3333 for TTY/TDD.

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