



BH CASE MANAGEMENT STATUS CHANGE NOTIFICATION
Fax to: 1-888-481-9739

Notification Type: <input type="checkbox"/> Request for discharge		<input type="checkbox"/> Unable to Contact	
Member			
Member Plan ID:		PROPOSED DISCHARGE DATE:	
Member Last Name:		Member First Name:	
Member Phone Number:		Date of Birth:	
Home Address:		Phone Number:	
Mailing Address:		Primary Contact:	
Treating Case Management Provider			
Provider ID:			
Case Management Agency:			
Phone Number:		Fax Number:	
Case Manager Name:		Case Manager Phone Number:	
Multiaxial Diagnosis			
Primary Axis I	Diagnosis Code:	Description:	
Primary Axis II	Diagnosis Code:	Description:	
Axis III Diagnosis (Medical Conditions):			
Axis IV (socio-legal):			
GAF Score:		Current LOCUS / Denver Score:	
Status Change Summary			
Reason for Discharge:			
<input type="checkbox"/> Member moved away		<input type="checkbox"/> Incarceration	
<input type="checkbox"/> Tx goals achieved		<input type="checkbox"/> Mutually agreed to discontinue	
<input type="checkbox"/> In a LTC Facility/ICF-MR facility		<input type="checkbox"/> Waitlisted or sent out of state for medical treatment	
<input type="checkbox"/> No longer eligible		<input type="checkbox"/> Transfer to another provider	
<input type="checkbox"/> Admission to Hawai'i State Hospital (HSH)		<input type="checkbox"/> Other:	
Unable to Contact = UTC			
<input type="checkbox"/> Member Never Engaged		<input type="checkbox"/> No Contact 3 Consecutive Months	
<input type="checkbox"/> No Contact 2 Consecutive Months		<input type="checkbox"/> No Contact 4 Consecutive Months	
Summary of dates and attempts to reach member MIA for four months or more:			
The following documents must be included with the request for disenrollment			
<input type="checkbox"/> Most recent Behavioral Health Assessment			
<input type="checkbox"/> Most recent Individualized Treatment Plan (must be submitted for all, even UTC)			
<input type="checkbox"/> Most recent LOCUS			

If the required documentation is not attached, provide summary of the explanation/justification:

Referrals made upon discharge:

BH Case Manager Name: _____

Date of submission : _____

If member's disenrollment is incomplete, your agency is still responsible for meeting the CM visit requirement according to acuity.

Unless member is incarcerated, the agency continues to be responsible through the last day of the month in which discharge was requested.