WellCare Health Plans | Heritage Health

Behavioral Health Discharge Summary

Please fax within 24 hours of discharge to WellCare at: 1-877-849-5071

Consider: *The purpose of the discharge review is to show the final disposition of the case and provide enough information to assist case management in follow-up care.*

Member Name:		**Member ID:**	
Authorization Number:		**Phone:**	
Member Address:			
Discharge Date:		**Level of Care at Discharge:**	
Facility:		**Staff Completing Form:**	
What level of care is the member being discharged to?			
Brief discharge summary of treatment received (for follow up by the case management team):			

BRIEF SUMMARY OF RECOMMENDATIONS FOR ONGOING TREATMENT

Discharged to where (home; guardian; shelter):	
Discharge diagnoses:	
Primary	
Secondary	
Additional diagnoses	
Does the member understand his/her DX?	☐ Yes ☐ No

DISCHARGE MEDICATION (PSYCHIATRIC AND MEDICAL)

Medication:	Dose:	Schedule:	Supply/Quantity Given at Discharge:	RX Provided:	If RX Provided, Quantity:	RX Prior Authorization Required:	Prior Authorization Completed:
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Does the member understand the reason for taking these medications?					☐ Yes ☐ No		

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FOLLOW-UP APPOINTMENTS Please schedule within 7 days of discharge and provide appointment details for all referred services.				
PCP/Other Providers Involved in Treatment:				
Appointment Type:	**Provider Name:**	**Provider Phone:**	**Appointment Date:**	**Appointment Time:**
☐ **Assessment (new to OP services)**				
☐ **Case Management**				
Is the member already enrolled in case management?		☐ **Yes** ☐ **No**	**If yes, date the CM was notified:**	
If no, was the CM referral offered?		☐ **Yes** ☐ **No**	**Accepted?** ☐ **Yes** ☐ **No**	
Is the Release of Information in the chart? ☐ **Yes** ☐ **No**				

Medication Management (for member discharged with psychiatric medications):				
A&D Treatment (for member with substance abuse/ dependence in the past year):				
Medical Condition (for member with a medical condition):				
Other recommended treatment:				

Do you have any concerns about the discharge plan?	☐ **Yes** ☐ **No**
If yes, explain:	
Was the member involved in the discharge planning?	☐ **Yes** ☐ **No**
If no, explain:	
Was a copy of the discharge plan provided to the member?	☐ **Yes** ☐ **No**
If no, explain:	