



Behavioral Health Discharge Clinical Form

Use this form to provide needed information for a Blue Cross and Blue Shield of Texas (BCBSTX) member recently discharged from Behavioral Health treatment.

Note: Complete this form in its entirety to ensure BCBSTX has accurate information and timely communication with the member if needed.

INSTRUCTIONS — **Step 1:** save the form to your desktop. **Step 2:** complete the form. **Step 3:** click "Submit Request" at the bottom to attach the encrypted document to open a pre-populated email that will go directly to the Behavioral Health Team.

Questions? Contact Behavioral Health Customer Service at **800-528-7264** for assistance.

Today's Date _____ Facility Contact Name/Phone _____

Member/Patient Demographic Information

First and Last Name _____ Date of Birth _____ Subscriber ID _____

Current Mailing Address _____
Street City State Zip Code

Parent/Guardian Name _____ Current Contact Phone # _____

Auth/Facility/Provider Information

Authorization #/Request ID _____

Facility Name _____

Level of Care _____ If PHP LOC, Total # Days Attended _____

Admit Date _____ Discharge Date _____

Discharge Aftercare Plan/Appointment Date and Time

Name of Psychiatrist: _____ Phone: _____ Date: _____ Time: _____

Name of Therapist: _____ Phone: _____ Date: _____ Time: _____

Name of Clinic: _____ Phone: _____ Date: _____ Time: _____

Name of PCP: _____ Phone: _____ Date: _____ Time: _____

Discharge Diagnoses and Medications

BH Diagnoses

1. _____ 2. _____

3. _____ 4. _____

BH Discharge Medications (Medication/Dosage/Frequency)

Medical Concerns/Diagnoses

Submit Request

Provider may also attach completed form to a secure email and send to BHUMClinicalRightfax@bcbstx.com or fax 972-766-9653.