



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 open a pre-populated, secure 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 or IOP 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.