



## Behavioral Health Inpatient Discharge Form

Tennessee | Medicaid

### Contact information for Wellpoint

Fax: 888-881-6287	Phone: 833-731-2153	Address: Behavioral Health Unit 22 Century Blvd., Suite 310 Nashville, TN 37214
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### Provider information

Provider name		NPI number	
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### Member information

Member name		Date of birth	
Wellpoint number	- - - - -		
Current auth number			
Parent/legal guardian name/ conservator		Relationship to member	<input type="checkbox"/> N/A <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/adoptive parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Foster parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Grandparents <input type="checkbox"/> Other: _____
Member/legal guardian/conservator primary telephone number	( ) - - - -	Type	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Other
Member/legal guardian/conservator other telephone number	( ) - - - -	Type	<input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Other
Member/legal guardian/conservator email address			

<https://provider.wellpoint.com/tn>

Medicaid coverage provided by Wellpoint Tennessee, Inc.

We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call 833-731-2154. Information about the civil rights laws can be found at [tn.gov/tenncare/members-applicants/civil-rights-compliance.html](https://tn.gov/tenncare/members-applicants/civil-rights-compliance.html).

TNWP-CD-079507-25-SRS78646 Matter ID: 25-0501 | May 2025

Discharge information			
Discharge to address	Street address		
	City		
	State	ZIP code	-----

Discharge date	--/--/----		
Discharge diagnosis	DSM code/name		
Clinical status at discharge			
Discharge disposition	<input type="checkbox"/> AMA <input type="checkbox"/> Acute facility <input type="checkbox"/> Home <input type="checkbox"/> IOP <input type="checkbox"/> PHP <input type="checkbox"/> RTC <input type="checkbox"/> Deceased <input type="checkbox"/> Housing program services <input type="checkbox"/> Other: _____		
Discharge level of care	<input type="checkbox"/> Home <input type="checkbox"/> SLE <input type="checkbox"/> B&C <input type="checkbox"/> Homeless shelter <input type="checkbox"/> Temp housing <input type="checkbox"/> Facility LOC <input type="checkbox"/> Housing program services <input type="checkbox"/> Other: _____		
Discharge medication(s)			
Follow-up appointment dates set up prior to discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If not, why wasn't discharge plan in place prior to discharge?	<input type="checkbox"/> Pt AMA <input type="checkbox"/> Declined referrals <input type="checkbox"/> Facility unable to identify provider <input type="checkbox"/> Offices closed at discharge <input type="checkbox"/> Pt/family refused discharge planning <input type="checkbox"/> Pt/family requested to schedule <input type="checkbox"/> Discharged over weekend/no discharge plan in place <input type="checkbox"/> Pt discharged over weekend, unable to set follow-up appointments <input type="checkbox"/> Moved to higher level of care
Was preapproval requested for antipsychotic medication(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

Step down facility information			
Step down facility name			
Step down facility telephone number	(____) ____-____		
Step down appointment date	--/--/----	Step down appointment time	__:_:____ <input type="checkbox"/> AM <input type="checkbox"/> PM

PCP			
PCP appointment made	<input type="checkbox"/> Yes      If yes, please complete below: <input type="checkbox"/> No		
PCP name			
PCP telephone number	(____) ____-____		
PCP appointment date	__/__/__	PCP appointment time	__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM

Tennessee Health Link			
Tennessee Health Link outreach made	<input type="checkbox"/> Yes      If yes, please complete below: <input type="checkbox"/> No		
Tennessee Health Link name			
Tennessee Health Link telephone number	(____) ____-____		
Tennessee Health Link appointment date (if applicable)	__/__/__	Tennessee Health Link appointment time	__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM
Tennessee Health Link outreach described			

1. Behavioral health provider information			
Name			
Provider's credentials (for example, psychiatrist, LCSW, LPC, etc.)			
Provider's telephone number	(____) ____-____		
Appointment date	__/__/__	Appointment time	__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM

2. Behavioral health provider information			
Name			
Provider's credentials (for example, psychiatrist, MFT, LCSW, etc.)			
Provider's telephone number	(____) ____-____		
Appointment date	__/__/__	Appointment time	__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM

Additional comments/ other aftercare plans	
Aftercare follow-up/ discharge planning	