meridiancomplete
1 Campus Martius, Suite 700
Detroit, MI 48226

1-855-580-1689
TTY: 711
www.mhplan.com

BEHAVIORAL HEALTH DISCHARGE TRANSITION OF CARE FORM

Behavioral Health Care Coordination

Complete this form and fax it to MeridianComplete and the member's PCP at the time of discharge.

Member Information

Member Name___________________________________
Member ID_____________________________________
D.O.B.____

Member's Discharge Demographics

Address____
City______________________ State_____ Zip________
Phone Number(s) ____________________________________

Check if any of the following apply upon discharge:

- ☐ Homelessness – lacks a fixed, regular and adequate nighttime residence.
- ☐ Imminent Risk of Homelessness – will imminently lose primary nighttime residence within 14 days or lacks the resources or support networks needed to obtain other permanent housing.
- ☐ High-Risk of Homelessness – has not had a lease, ownership interest or occupancy agreement in permanent housing during the last 60 days or had two or more moves during the preceding 60 days.

Acute Service Provider Information

Admitting Service Provider________________________
____

Admit Date___________ Discharge Date____________

DSM - 5 Diagnosis

ICD-10 Code	Diagnosis

Reason for Admit

BH Status upon Discharge

Significant Medical History

Medical Intervention, if Applicable

Primary Care Provider (PCP) Coordination

PCP Name ____________________________________
PCP Phone # __________________________________
PCP Fax # ____________________________________
Date last notified _____________________________
Faxed this form to PCP? ☐Yes ☐No
If no, why? ____
____

PCP Appointment upon Discharge

Appt. Date ____________ Appt. Time ____________

BH Appointment (within 7 days of discharge)

Provider Name _________________________________
Provider Phone # _______________________________
Appt. Date ____________ Appt. Time ____________

BH Appointment (within 30 days of discharge)

Provider Name _________________________________
Provider Phone # _______________________________
Appt. Date ____________ Appt. Time ______________

Clinic or Support Group Appointment (optional)

Agency Name __________________________________
Appt. Date ____________ Appt. Time ______________

Discharge Medication

	Name Dose Qty. Date	Meds	Script
1.	__________________________	☐	☐
2.	__________________________	☐	☐
3.	__________________________	☐	☐
4.	__________________________	☐	☐
5.	__________________________	☐	☐
6.	__________________________	☐	☐

Member given copy of discharge plan upon discharge?
☐Yes ☐No

Use additional forms if necessary. Please fax to the MeridianComplete Behavioral Health department at 1-312-980-0444.