author by Humana

Behavioral Health Discharge Summary Form

Use this form when sharing information about post-discharge health care needs for members with service from Author by Humana. Please type or print legibly and complete the entire form before submitting. Circle or check responses where applicable.

For any questions, please contact an Author by Humana Provider Navigator at 1-833-502-2013, from 8 AM to 5 PM Eastern time, Monday through Friday.

Today's Date: _____

Patient Name: _____

Patient DOB: _____ Member ID Number: _____

Provider Name: _____

Provider Phone: _____ Provider Fax: _____

Provider Tax ID #: _____ Provider NPI #: _____

Insurance Co: _____

Discharge Date: _____

For Outpatient Services:

Date of Most Recent Session: _____ Number of Sessions to Date: _____

For Inpatient Services:

Date of Admission: _____ Number of Days in Care: _____

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Discharge Diagnosis: _____

Level of care from which patient is discharged: _____

Prognosis *(Explain)*: _____

Discharge Medications *(List Psychiatric Medications)*:

Medication:	Dose & Frequency:
_____	_____
_____	_____
_____	_____
_____	_____

Follow-up Treatment Plan (Must reflect the level of care. Any step-down must occur within 7 days of discharge from previous care.):

Patient is being stepped down to which level of care? *(Circle One)*: **RTC PHP IOP OP**

Provider/Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Session Date: _____ Time: _____

Provider/Facility Name: _____

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Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Session Date: _____ Time: _____

Other aftercare and/or follow up visits planned: _____

_____

Does patient have adequate aftercare in place? Yes _____ No _____

With community health outreach and comprehensive discharge planning, Author by Humana is committed to supporting your patient's behavioral health needs. If you would like to be contacted for more information on behavioral health services, please check "yes" below.

Yes _____ No _____

Please list any unmet needs: _____

_____

_____

Notes:

- Failure to provide discharge plan information to Author by Humana Behavioral Health may result in an administrative non-certification. This may result in the provider being paid at a lower benefit and the patient having a greater out-of-pocket expense. If the patient's benefit plan does not allow for reimbursement of non-certified care, the provider may not be reimbursed.
- All certifications are based on clinical criteria. Certification of care is not a confirmation of benefit eligibility or guarantee of claim payment. Final determination of claim reimbursement is made at the time the claim is processed. All additional sessions must be pre-certified.
- If form is incomplete or information is inadequate, additional information may be requested prior to a determination of certification.

Provider Signature: _____ **Date:** _____