



Behavioral Health Discharge Clinical Form

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

Note: Complete this form in its entirety to ensure BCBSIL 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 800-851-7498 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 (1-4)
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.