

SUBMIT TO

Utilization Management Department
5900 E. Ben White Blvd.
Austin, TX 78741
PHONE 1-844-842-2537 | FAX 1-877-650-6938



**superior
healthplan™**

DISCHARGE CONSULTATION DOCUMENTATION

Please complete all information requested on this form. Fax to 1-877-650-6938

DISCHARGE CONSULTATION INFORMATION

Member Name: _____ Member Phone: _____
Member DOB: _____ Parent / Guardian Name: _____
Member ID Number: _____ Best Time to Reach Member/Parent/Guardian: _____
Member Address: _____ UM Name: _____
Facility Name: _____ Emergency/Other Contact: _____
Facility Fax number: _____

Outpatient Therapist: _____ Psychiatrist: _____
Outpatient Therapist Phone: _____ Psychiatrist Phone: _____
Date of next appointment: _____ Date of next appointment: _____
Case Manager (if applicable): _____ Does the member have medication to last until this follow-up? Yes No
Case Manager Phone: _____

Other follow-up appointments: _____
Name/Type of Provider: _____ Phone: _____
Date of next appointment: _____

*****All appointments following a discharge are required to be set within seven calendar days with a licensed behavioral clinician. Any appointments outside this time frame will need to be reported to Superior to allow for assistance with the appropriate level of follow-up.**

Medical Provider/PCP: _____ Phone: _____
Current ICD Diagnosis:
Primary: _____
Secondary: _____
Tertiary: _____
Medication at discharge: _____

Discharge Disposition (where will the member be staying after discharge?): _____

Signature of Facility Staff

Signature of Member/Guardian

Date of Admission/Discharge

Time of Discharge