PROPRIETARY
Magellan Healthcare

Bridge to Home Coordination Form

Discharge Date: _____ **Last Covered Date:_____**

Follow-Up Appointment Date: _____

Please fax completed form to: **WHA Fax: 888-656-4789** **OR BSC Fax: 888-656-0467**

****** To request a formal step down prior auth needed. Please call in clinical info.***

ALL 5 Sections below must be completed. Please Print! Thank you.

Section 1: Discharge service location and UR/DISCHARGE PLANNER/PRACTITIONER RENDERING discharge service	
Facility Name	Address
TIN	State, Zip
NPI	
PRINT UR/Practitioner Name:	UR/Disch Planner/Practitioner Phone #:
SIGNATURE	Credential:
☐ Check the box to attest that the information below has been discussed with the member	

Section 2: MEMBER INFORMATION (Please ask the member for the most up-to-date information)	
Member Name	Member Address
Insurance ID	Member State, ZIP
Member DOB	Member Cell Phone #:
Discharge Date:	
☐ Member gives permission to be texted with reminders of follow up visits **(Valid only with patient signature)** Member Signature_____	

SECTION 3: FOLLOW-UP APPOINTMENT INFORMATION

Please call the toll free number for either WHA (800-424-1778) or BSC (877-263-9952) to contact a Magellan Follow-up Specialist immediately if you have difficulty scheduling an appointment

1st Appointment (Schedule within 7 days, not including the day of discharge)

Name of Provider/Credentials:_____Phone:_____

Date:_____ Time:_____

How will the person get to the appointment/s?_____

Aftercare Levels of Care: *(check one)*

☐ Transfer to IP BH Facility ☐ Transfer to Med/Surg Facility ☐ Residential ☐ PHP ☐ IOP ☐ Outpatient
☐ Skilled Nursing ☐ Groups/Community Support ☐ Other_____

Provider Type: *(check one)*

☐ Psychiatrist ☐ Psychologist ☐ Psych Nurse ☐ Master Therapist ☐ Social Worker ☐ Other_____

Follow Up Appointment Type: (check one)
☐ In Office ☐ In Home (Member's) ☐ Telehealth

If no appointment is scheduled, please provide explanation and action taken. ***Why no appt?*** ☐ Member Refused Aftercare; ☐ Preferred visit with PCP; ☐ Member Discharged AMA; ☐ Provider unable to give timely appointment; ☐ Co-pay; ☐ Transportation ☐ Other _____

Section 4: CLINICAL STATUS/DISCHARGE MEDICATIONS/INSTRUCTIONS:

Clinical Status on Discharge:

List patients' discharge medications and amount (number of days supply) at time of discharge:

Medication and dosage	Days Supply	Medication and dosage	Days Supply
1.		4.	
2.		5.	
3.		6.	

Check the boxes to attest that the following actions were completed prior to discharge:
☐Medication reconciliation performed ☐Patient educated on medication
☐Discharge instructions reviewed with patient ☐Barriers to getting to appointment(s) addressed with patient

SECTION 5: Discharge service ENCOUNTER

Date of Service	**$ Amount**	Authorization# if applicable

PRIMARY ICD-10 DIAGNOSIS CODE REQUIRED R69 is not accepted Primary psychiatric disorder

Enter code _ _ _ . _ _ _ **or** for your convenience you may select one from the list below**:**

☐ Major Depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior (ICD10-CM F33.2)
☐ Bipolar disorder, unspec (ICD10-CM F31.9) ☐ Schizoaffective disorder, unspec (ICD10-CM F25.0)
☐ Depressive disorder NEC (ICD10-CM F32.9) ☐ Psychosis (ICD10-CM F28) ☐ ADHD (ICD10-CM F90.1)
☐ Recurring Depressive psychosis (ICD9-CM F33.9) ☐ Episodic mood disorder (ICD10-CM F39)

ENCOUNTER TRANSACTION CODING:POS 22 HCPCS/CPT 99402 Modifier AJ