MOLINA HEALTHCARE

Psychiatric Inpatient Discharge Form

Phone Number: 1-866-449-6849 Fax Number: 1-866-617-4967

Section 1 Member Information	
Member Name: (Last, First, MI)	Member ID:
Member Address at Discharge: (No., Street, City, State, Zip)	Phone Number at Discharge:
Do you require assistance with a referral for follow up with our Molina Member: ☐ Yes ☐ No	
Please describe referral needs:	

Section 2 Facility Information		
Provider/Facility: Address:	Phone Number:	Fax Number:
NPI:	**TPI:**	

Section 3 Discharge Information	
Admit Date (required):	Discharge Date:

Section 4 DSM-IV at Discharge		
Axis I (Include all):	Axis II:	
Axis III:	Axis IV:	Axis V GAF:

Section 5 Discharge Medications
Medication at Discharge:

Section 6 Follow Up Information
Follow up *(check all that apply):* ☐ PCP ☐ Psychiatrist ☐ Therapist ☐ Other (Specify: _____)
Appointment Dates: Times:
Provider Information for Follow up Appointments *(Name and Contact Information):*

**Per HEDIS guidelines, an outpatient visit with a mental health practitioner is required within 7 days after discharge. Please contact Molina Healthcare at 866.449.6849 if assistance is needed in scheduling this appointment.

Signature *(Person completing form)*: Title:

Additional Information (For Molina Healthcare of Texas Use Only):