

# Commercial Plans: Behavioral Health Discharge Summary

PO Box 66189  
Virginia Beach, VA 23466

Please submit via the provider portal or  
fax to **757-431-7763** or **1-844-723-2096**

Member Name/Last, First	Member ID/Policy#	Date of Birth/Age	Today's Date

Facility Name: \_\_\_\_\_

Attending MD: \_\_\_\_\_ UM Contact Name: \_\_\_\_\_

UM Fax Number: \_\_\_\_\_ UM ContactPhone: \_\_\_\_\_

Admit Date: \_\_\_\_\_

Psychiatric Discharge Diagnosis Listed: \_\_\_\_\_

Medical Concerns: \_\_\_\_\_

Discharge Medications (Include Name, Dose, and Frequency): \_\_\_\_\_

\*\*\*If Decanoate or Invega Sustenna, note the last date medication was received  
and next date medication is to be administered\*\*\*

### **Discharge Disposition Information:**

Discharge Date \_\_\_\_\_ Disposition \_\_\_\_\_

Name of Parent/Guardian, If Applicable: \_\_\_\_\_

Disposition Address at Time of Discharge: \_\_\_\_\_

Disposition Phone Number: \_\_\_\_\_

Follow up appointments: Please provide date/time of the appointment(s), provider's first and last name, and the provider's office phone number.