Horizon Blue Cross Blue Shield of New Jersey

Three Penn Plaza East
Newark, NJ 07105-2200
HorizonBlue.com

Within 24 hours of discharge, please fax this information to 855-207-1240.

Demographic Information

Member's Name: _____
Last *First* *M.I.*

Discharge Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Birth Date: _____ Member ID: _____

Who does member live with: _____

Discharge Information

Discharging Facility: _____ Level of Care: _____

Admission Date: _____ Discharge Date: _____

Other Diagnoses: _____

Total number of units used during this admission: _____

Primary Diagnosis: _____ GAF: _____

Medications: _____

(name, dosage, frequency and route) _____

Aftercare Information – Behavioral Health (e.g., Therapy)

Provider: _____ Level of Care: _____

Address: _____
Street Address *Phone Number*

_____
City *State* *ZIP Code*

Date of Appointment: _____ Time of Appointment: _____

Aftercare Information – Medication Management

Provider: _____ Level of Care: _____

Address: _____
Street Address *Phone Number*

_____
City *State* *ZIP Code*

Date of Appointment: _____ Time of Appointment: _____

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Aftercare Information – Other

Provider: _____
Facility/Provider Name

_____
Street Address *Phone Number*

_____
City *State* *ZIP Code*

Date of Appointment: _____ Time of Appointment: _____

Condition Upon Discharge (Including Mental Status)

Member's condition at discharge (please check one): ____ Improved ____Worsened ____ No Change

Discharge Type: ____ Planned ____AMA

Comments: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of Person Completing Form: _____ Phone Number: _____

If available, please attach discharge summary.