Pennsylvania's Children's Health Insurance Program
We Cover All Kids.

Keystone First

Coverage by Vista Health Plan,
an independent licensee of the Blue Cross and Blue Shield Association.

Intensive Outpatient (IOP) Discharge Summary

If this is an Out of Network request, please submit via Fax: 1- 844-329-9100. In network providers submit via NaviNet

Enrollee's Name: _____ CHIP ID#: _____

Provider: _____

Level of Care Being Discharged: ☐ Mental Health IOP ☐ Substance Use IOP

Date of Admission: _____ Date of Discharge: _____

Reason for Discharge: _____

Treatment Outcome:

Were referrals for aftercare services or supports made? If so, when and to which service(s) was a referral made? Please also indicate any referrals to natural/community supports.

Aftercare Service	Provider	Provider Contact Name/Number	Appointment Date/Time	Date of Referral

Diagnoses at Discharge: _____

Medications Currently Prescribed at Discharge: _____

Staff Completing Form: _____ Date: _____

☐ By checking this box, I acknowledge I have provided a copy of this document to the Enrollee/Parent/Legal Guardian.