

**Inland Empire Health Plan**

**Behavioral Health Treatment (BHT) Exit Letter**

1. ***GENERAL INFORMATION:***

|  |  |  |  |
| --- | --- | --- | --- |
| **First Name:** |  | **Last Name:** |  |
| **Birth Date:** |  | **IEHP Member ID#:** |  |
| **Present Address:** |  | | |
| **Parent/Guardian:** |  | **Phone:** |  |
| **Language:** |  | **Referral Date:** |  |
| **Letter Date:** |  | **Provider name/Certification:** |  |

1. ***Discharge:*** *Within this section include a description regarding the discharge of the Member.*

***Example:*** *(Provider name) is discharging (Member name) due to no staff being available to service the Members home address. Member will be redirected back to IEHP.*

***Please note:****Exit reports are required for Members aging out of the BHT benefit at 21 years old. Authorizations for BHT will not extend past the Member’s 21st birthday. For Members who are within sixty (60) days of their 21st birthday, the BHT Provider must initiate the transition process to an alternative funding source (e.g., Regional Center, County Services, or Department of Rehabilitation).*

**Letter completed by:**



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date:

Title

Agency Name

**Letter reviewed and approved by: *The Health plan requires a second review by BCBA***



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Name Date:

Title

Agency Name