Excellus

Health Home Notification of Transition
***To be completed and submitted prior to discharge meeting with Excellus BlueCross BlueShield**

Member Health Home: _____

Member Care Management Agency: _____

Health Home Care Manager name and contact information:_____

Member name: _____

Date of birth: _____ Medicaid CIN: _____

Member address: _____

Member phone number: _____

Product: MMC___ HARP___

Anticipated Discharge Date: _____

Please include with this form the following:

Document	Included?
DOH consent form, listing consent for Excellus BCBS	
Most recent Plan of Care or current goals	
Most recent pertinent medical history (inclusive of physical health and behavioral health) and SDoH needs	
List of current medications	
List of current providers and contact information	
Note indicating member's current needs	

Please ***submit this checklist and documents*** via secure email to: healthhomeservicesexcellus@excellus.com