Behavioral Health Service Request Form

Detox and Substance Abuse Rehab
Please submit to the WellCare Advocate Complete FIDA (Medicare-Medicaid Plan) dedicated fax line: 1-855-713-0590

****Medicare: Please note – rehab is only covered if services are provided in an inpatient hospital setting. (POS 21)**		
☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan 14 days prior to the date the requested services will be performed.
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request _____ Date Signed _____

MEMBER INFORMATION

Last Name:		**First Name, Middle Initial:**		**Date of Birth:**	
Phone:		**Member ID:**		**Gender:**	☐ **Male** ☐ **Female**
Third Party Insurance:	☐ **Yes** ☐ **No**	If **yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.		**Languages Spoken:**	

TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name:		**First Name:**		**NPI Number:**	
Provider ID:		**Participating:**	☐ **Yes** ☐ **No**	**Discipline/Specialty:**	
Address:		**City and State:**		**ZIP:**	
Phone:		**Fax:**		**Office Contact:**	

FACILITY/AGENCY INFORMATION

Name:		**Facility ID:**		**NPI Number:**	
Address:		**City and State:**		**ZIP:**	
Phone:		**Fax:**		**Office Contact:**	

SERVICE TYPE REQUESTED	POS	LIST REV/CPT/HCPCS CODE(S) AND NUMBER OF EACH REQUESTED
Detox:		
Rehab:		

Requested Start Date:	**Expected Discharge Date:**	**Original Admission Date:**	**Transition of Care:** ☐ **Yes** ☐ **No**
Signed Order Attached: ☐ **Yes** ☐ **No**	All requests require current, dated physician's orders as written or given if verbal.	**Court Ordered:** ☐ **Yes** ☐ **No**	

DSM-IV DIAGNOSIS (AXIS I–V)

Primary Diagnoses:		**R/O:**	
Secondary Diagnoses:		**R/O:**	
Medical Problems:			

Current GAF/CAFAS:		**Highest GAF/CAFAS in the Past Year:**	
Current CIWA Score:		**Current ASAM Dimension Scores (if applicable):**	

WellCare Health Plans

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INITIAL REVIEW REQUESTS

Is the member currently an inpatient? ☐ Yes ☐ No	Is the member currently receiving outpatient services? ☐ Yes ☐ No
Has the member exhausted all lower levels of care? ☐ Yes ☐ No	

Previous Treatment History:	Dates of Treatment:	Facility:	Successful:
Inpatient/detox:			☐ Yes ☐ No
Substance abuse rehab:			☐ Yes ☐ No
IOP/PHP:			☐ Yes ☐ No
Outpatient:			☐ Yes ☐ No

If the placement was not successful, please explain:	
Drug(s) of Choice:	
Is the member currently intoxicated? ☐ Yes ☐ No	
Is the member currently experiencing withdrawal symptoms? ☐ Yes ☐ No	

Please check all withdrawal symptoms the member is experiencing.

Physiologic:				Changes in Mood/Personality/Behavior:	
Hand tremors:	☐	Impaired attention/memory:	☐	Psychomotor agitation:	☐
Sweating/weakness:	☐	Nausea/vomiting:	☐	Anxiety/irritability:	☐
Nystagmus:	☐	Fluctuating vital signs:	☐	Insomnia:	☐

Vital signs:
Has the member been medically cleared? ☐ Yes ☐ No
Please attach the initial plan of care (IPOC) with all required elements, including individual therapy (quantity/frequency/length), treatment interventions (frequency) and family therapy as applicable.
Date of the physician's signature on the completed IPOC:

CURRENT SYMPTOMS

Circle the impairment level for each category.

Scale: 0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; N/A = Not Assessed

Depressed mood:	0 1 2 3 N/A	Substance abuse/dependence:	0 1 2 3 N/A
Nausea and vomiting:	0 1 2 3 N/A	Agitation:	0 1 2 3 N/A
Tremor:	0 1 2 3 N/A	Generalized anxiety:	0 1 2 3 N/A
Paroxysmal sweats:	0 1 2 3 N/A	Visual disturbances:	0 1 2 3 N/A
Job/school problems:	0 1 2 3 N/A	Memory impairment:	0 1 2 3 N/A
Delusions:	0 1 2 3 N/A	Impaired judgment:	0 1 2 3 N/A
Tactile disturbances:	0 1 2 3 N/A	Headache, fullness in head:	0 1 2 3 N/A
Auditory disturbances:	0 1 2 3 N/A	Orientation and clouding of sensorium:	0 1 2 3 N/A
Suicidal/Homicidal: ☐ Ideation ☐ Plan ☐ Means (include previous attempts and when)			0 1 2 3 N/A
Hallucinations: ☐ Auditory ☐ Visual ☐ Command			0 1 2 3 N/A
Relationships:			
Role Performance Job/School:			
Current Living Situation:			

Date Problem Began:	Duration:	Is the member under the care of a psychiatrist? ☐ Yes ☐ No

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Presenting problem to be addressed by the treatment plan:			
Discharge plan detail:			
CURRENT MEDICATIONS (PSYCHOTROPIC AND MEDICAL)			
Medication:	**Dosage:**	**Frequency:**	**Adherent:**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Any medication contraindications? If yes, describe:			