Behavioral Health Service Request Form

Residential Treatment Request Form
Please submit to the WellCare Advocate Complete FIDA (Medicare-Medicaid Plan)
dedicated fax line: 1-855-713-0590

☐	**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	LIST REV/CPT/HCPCS CODE(S) AND NUMBER OF EACH REQUESTED		
Residential:			
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 Total LOCUS/CALOCUS Score (if applicable):		**Current ASAM Dimension Scores (if applicable):**	

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:**
Inpatient:	

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IOP/PHP:	
Outpatient:	
Intensive community-based treatment:	

Alternative placements tried or explored in the past year? ☐ Yes ☐ No

Name of Placement:	Dates:	Successful:
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

If placement was not successful, please explain:

Initial plan of care (IPOC) with all required elements, including individual therapy (quantity/frequency/length), treatment interventions (frequency) and family therapy as applicable, completed, signed and dated as requested?	☐ Yes ☐ No

Date of physician’s signature on completed IPOC:

MENTAL STATUS EXAM AND SYMPTOMS

Circle the impairment level for each category and provide a brief description.

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
Self-mutilation:	0	1	2	3	N/A	Obsession/compulsion:	0	1	2	3	N/A
Impaired attention/concentration:	0	1	2	3	N/A	Generalized anxiety:	0	1	2	3	N/A
Impulsivity:	0	1	2	3	N/A	Cruelty to animals:	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
Eating disorders:	0	1	2	3	N/A	Lack of insight:	0	1	2	3	N/A
Fire setting:	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

Presenting problem to be addressed by the treatment plan:

Discharge plan detail:

CONTINUED STAY REVIEWS

For continued stay, provide a narrative of the current symptoms/behaviors that support the need for residential care. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.

Circle the impairment level for each category and provide a brief description.

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

Functioning:	0	1	2	3	N/A
Ability to follow instructions:	0	1	2	3	N/A
Complete assignments:	0	1	2	3	N/A
Perform activities of daily living (ADLs):	0	1	2	3	N/A

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Types of Services Offered:	Total Number of Sessions Attended:	Member Cooperative with Treatment:	Please provide an explanation for any sections checked "No."
Individual counseling:		☐ Yes ☐ No	
Group counseling:		☐ Yes ☐ No	
Psychiatric interventions:		☐ Yes ☐ No	
Family counseling:		☐ Yes ☐ No	
Substance abuse counseling:		☐ Yes ☐ No	
Sexual reactive treatment:		☐ Yes ☐ No	
Sexual offender treatment:		☐ Yes ☐ No	
Other services:		☐ Yes ☐ No	

Has the member's behavior necessitated a significant change in treatment or supervision? ☐ Yes ☐ No
If yes, please describe the changes (use a separate sheet if necessary):

Updates to the discharge plan:	Expected Discharge Date:

Intervention Methods:	Frequency:	Has the use of these methods become more frequent? If so, please explain.
Use of time-out:		
Physical management/restraint (does not include escorts or assists):		
Calls for outside assistance (law enforcement, non-agency staff, etc.):		
Other:		

Does the member have any chronic illnesses that require staff supervision? If yes, indicate the illness, severity and how staff time and resources are utilized:

Has the member experienced any acute illnesses, medical complications or medical hospitalizations during the last 3 months?

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:

ATTACHMENTS

☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other:

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