Behavioral Health Service Request Form

Covered Routine Outpatient Services
Please submit to the WellCare Advocate Complete FIDA (Medicare-Medicaid Plan)
dedicated fax line: 1-855-550-8977

☐	**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**
Traditional Outpatient Individual/Family/Group Therapy:	
Other Comprehensive Community Services:	

Requested Start Date:	**Requested End Date:**	**Transition of Care:** ☐ Yes ☐ No	**Continuation of Care:** ☐ 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):**	

RATIONALE FOR REQUEST

Is a psychiatrist involved in the member's care? ☐ Yes ☐ No	**When was member last seen?**
Presenting problem (please describe):	
Ongoing problem (please describe):	

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CURRENT IMPAIRMENTS	
Circle the impairment level for each category and give a brief description. **Scale: 0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; N/A = Not Assessed**	
Risk of harm:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Functional status:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Co-morbidities:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Environmental stressors:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Support in the environment:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Response to treatment (if poor response, how is the treatment plan being adjusted to address):	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Acceptance and engagement:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
***If services are for ACT or Therapeutic Rehab Program, please submit a treatment plan/updates.	