Behavioral Health Service Request Form

Inpatient, Sub-Acute and CSU Services

Please fax to the appropriate plan fax number listed below.

MEDICARE PLANS			MEDICAID PLANS
Arizona: **1-888-834-8387**	Kentucky: **1-888-365-5615**	Ohio: **1-855-710-0163**	Georgia: **1-888-361-6574**
Arkansas: **1-855-710-0159**	Louisiana: **1-855-710-0159**	South Carolina: **1-855-710-0159**	Kentucky: **1-877-338-3686**
Connecticut: **1-888-365-3233**	Mississippi: **1-855-710-0159**	Tennessee: **1-855-710-0159**	Illinois: **1-855-713-0594**
Florida: **1-855-710-0167**	Missouri: **1-855-710-0161**	Texas: **1-855-671-0258**	New Jersey: **1-855-703-8082**
Georgia: **1-855-710-0165**	New Jersey: **1-855-703-8082**		New York: **1-855-713-0590**
Illinois: **1-855-713-0592**	New York: **1-855-713-0588**		
MEDICARE–MEDICAID PLANS			
WellCare Advocate Complete FIDA (Medicare-Medicaid Plan): **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

CHOOSE ONE OF THE FOLLOWING

Place of Service:	☐	**Inpatient**	☐	**Sub-Acute**	☐	**CSU**

Please contact the Health Plan for prior authorization of inpatient services at the time of admission or on the next business day following admission to a psychiatric inpatient program. After the initial authorization determination, providers will be required to perform concurrent review for any additional inpatient days authorized. This form should be used by providers to ensure the review process will be as quick and efficient as possible.

NOTE: *McKesson InterQual criteria are used as a tool to assist with determining medical necessity. Medical necessity criteria and treatment guidelines can be found at* ***<Web Address>****.*

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**		
Acute Inpatient:			
Crisis Stabilization Unit:			
Extended Care/Sub-Acute Unit:			
Requested Start Date:	**Requested End Date:**	**Transition of Care:** ☐ **Yes** ☐ **No**	**Continuation of Care:** ☐ **Yes** ☐ **No**

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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

CURRENT RISK

Circle the risk level for each category and check all boxes that apply.

Risk level scale: 0 = None; 1 = Mild, ideation only; 2 = Moderate, ideation with either a plan or history of attempts; 3 = Severe, ideation AND plan, with either intent or means

Risk to self (SI):	0 1 2 3	With: ☐ Ideation ☐ Intent ☐ Plan ☐ Means
Risk to others (HI):	0 1 2 3	With: ☐ Ideation ☐ Intent ☐ Plan ☐ Means

Current serious attempt or gesture:	☐ Yes ☐ No (if yes, describe):	Circle: SI HI
Date of most recent attempt or gesture:		
Prior serious attempt or gesture:	☐ Yes ☐ No (if yes, describe):	Circle: SI HI

CURRENT IMPAIRMENTS

Circle the impairment level for each category.

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

Mood disturbance (i.e., depression, mania):	0 1 2 3 N/A
Anxiety:	0 1 2 3 N/A
Psychosis:	0 1 2 3 N/A
Thinking/cognition/memory:	0 1 2 3 N/A
Impulsiveness/recklessness/aggressiveness:	0 1 2 3 N/A
Activities of daily living (ADLs):	0 1 2 3 N/A
Weight change associated with behavioral health diagnosis: ☐ Gain ☐ Loss _____ lbs. in last 3 months	0 1 2 3 N/A
Medical/physical conditions:	0 1 2 3 N/A
Substance abuse/dependence:	0 1 2 3 N/A
Job/school performance:	0 1 2 3 N/A
Social/marital/family problems:	0 1 2 3 N/A
Legal:	0 1 2 3 N/A
Stressors (orientation/alertness/awareness):	0 1 2 3 N/A

Support system (please describe):	
Current Living Situation: ☐ Spouse ☐ Family ☐ Homeless	**Please describe:**

WellCare Health Plans

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ADDITIONAL DATA TO SUPPORT REQUEST	
Is a psychiatrist involved in the member's care? ☐ Yes ☐ No	
If yes, when was the member last seen and what services are being rendered?	
Is there a history of hospitalization in the past year? ☐ Yes ☐ No	
Name of Facility:	**Dates:**
Is the member at risk of legal intervention or out-of-home placement? Please describe:	
Describe the overall risk of harm (to self or others):	
What are the environmental/community stressors and/or supports that contribute to the member's clinical status?	
Describe the member/family engagement in the treatment:	
Expected discharge date:	
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:			