

Behavioral Health Service Request Form

Inpatient, Subacute and CSU Services

Medicare

Call for Pre-certification of Admissions: 1-855-538-0454

Please Submit to the Dedicated Fax Line Below

Arizona: **1-855-713-0592**

Kentucky: **1-888-365-5615**

Florida: **1-855-710-0167**

New Jersey: **1-855-671-0257**

Hawaii: **1-888-890-8219**

New York: **1-855-713-0588**

Connecticut, Maine, North Carolina: **1-888-365-3233**

Texas: **1-855-671-0258**

Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: **1-855-710-0159**

Illinois, Iowa, Michigan, Missouri, Washington: **1-855-713-0592**

Georgia: Medicare Only Members **1-877-892-8213**, Dual Eligible Members **1-855-292-0233**

Retro Request – Please indicate if the services are completed and the member is no longer in Inpatient care. Please submit the member record for review.

Level of Care: Inpatient Subacute CSU

Place of Service:

21-Inpatient Hospital 51-Inpatient Psychiatric Hospital 53-Community Mental Health Center

Please contact Wellcare for 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 must perform concurrent review for any additional Inpatient days authorized. This form should be used by providers to ensure our review process will be as quick and efficient as possible.

Member Information

Last Name:

First Name, Middle Initial:

Date of Birth:

Phone Number:

Wellcare ID Number:

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:

Wellcare ID Number:

Participating: Yes No

Discipline/Specialty:

Street Address:

City, State:

ZIP:

Phone Number:

Fax Number:

Office Contact:

(continued)

Facility/Agency Information

| | | |
|-----------------|--------------|-----------------|
| Name: | Facility ID: | NPI Number: |
| Street Address: | City, State: | ZIP: |
| Phone Number: | Fax Number: | Office Contact: |

Service Type Requested REV/HCPCS Code(s)

| | | | |
|-----------------------------|---------------------------|---|---|
| Detox | | | |
| Rehab | | | |
| Service Request Start Date: | Projected Length of Stay: | Original Admission Date (if different from Start Date Requested): | Transition of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | Continuation of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Diagnosis – Code and Description

Primary Diagnosis:

Secondary Diagnosis:

Medical Diagnoses:

Are services requested court-ordered? Yes No
If yes, please submit a copy of the court order and all supporting documentation.

Reason for Admission

Presenting problem to be addressed by treatment plan:

| | | | |
|---------------------|-----------|--|--|
| Date problem began: | Duration: | Is member under the care of a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is member currently inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the current length of stay? |
|---------------------|-----------|--|--|

Is member currently receiving Outpatient services? Yes No
If yes:

| Name of Provider/Facility | Dates | Compliant |
|---------------------------|-------|--|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

I acknowledge that I am required to send a report of the member's admission to inpatient services to their PCP, and I will update their PCP quarterly.

Current Risk

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.

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

| | | |
|---|---|--|
| Risk to self (SI) | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 | With: <input type="checkbox"/> ideation <input type="checkbox"/> intent <input type="checkbox"/> plan <input type="checkbox"/> means |
| Risk to others (HI) | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 | With: <input type="checkbox"/> ideation <input type="checkbox"/> intent <input type="checkbox"/> plan <input type="checkbox"/> means |
| Current serious attempt or non-suicidal self-injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: | Check: <input type="checkbox"/> SI <input type="checkbox"/> HI Date of attempt: | |
| Prior serious attempt or non-suicidal self-injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: | Check: <input type="checkbox"/> SI <input type="checkbox"/> HI Date of attempt: | |

Current Impairments

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed

Check the impairment level for each category and please provide brief description of any severe (3) impairments.

| | | |
|--|--|--|
| Mood Disturbance (depression, mania) | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Anxiety | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Psychosis | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Thinking/cognition/memory | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Impulsive/recklessness/aggressive | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Activities of daily living | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Weight change associated with behavioral health diagnosis <input type="checkbox"/> gain <input type="checkbox"/> loss lbs. in past three months | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Medical/physical conditions | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Substance abuse/dependence | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Job/school performance | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Social/marital/family problems | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Legal | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Stressors | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |
| Orientation/alertness/awareness | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A | |

Current/Previous Treatment

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?

History of hospitalization in the past year? Yes No

| Name of Facility | Dates |
|------------------|-------|
| | |
| | |
| | |

Is a therapist currently involved in the members care? Yes No

| Name of Current Provider/Facility | Dates | Compliant |
|-----------------------------------|-------|--|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please list any other treatment received over the past two years:

| Name of Provider/Facility | Dates | Compliant |
|---------------------------|-------|--|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Current Medications (Psychotropic and Medical)

| Medication | Dosage | Frequency | Compliant |
|------------|--------|-----------|--|
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Are there any medication contraindications? Yes No

If yes, please describe:

Additional Clinical Information

Is the member at risk of legal intervention or out-of-home placement? 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?

Support System (describe):

Describe the member/family engagement in treatment:

Current living situation: Homeless Independent Family Foster home Incarcerated
 Other:

Detail the discharge plan: