

# Behavioral Health Service Request Form



## IOP Services as Covered

Please submit to the dedicated fax line below.

Medicare			
Arizona: <b>1-855-713-0593</b>		Kentucky: <b>1-888-365-5676</b>	
Florida: <b>1-855-710-0168</b>		New Jersey: <b>1-888-339-2677</b>	
Hawaii: <b>1-888-881-8225</b>		New York: <b>1-855-713-0589</b>	
Connecticut, Maine, North Carolina: <b>1-888-365-5607</b>		Texas: <b>1-855-671-0259</b>	
Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: <b>1-855-710-0160</b>			
Illinois, Iowa, Michigan, Missouri, Washington: <b>1-855-713-0593</b>			
Georgia: Medicare Only Members <b>1-877-892-8213</b> , Dual Eligible Members <b>1-855-292-0233</b>			
Place of Service: <input type="checkbox"/> 22-Outpatient Hospital <input type="checkbox"/> 53-Community Mental Health Center			
Treatment Focus: <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Dual Diagnosis			
Member Information			
Last Name:		First Name, Middle Initial:	Date of Birth:
Phone Number:		Wellcare ID Number:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Third-Party Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Discipline/Specialty:
Street Address:		City, State:	ZIP:
Phone Number:		Fax Number:	Office Contact:
Facility/Agency Information			
Name:		Facility ID:	NPI Number:
Street Address:		City, State:	ZIP:
Phone Number:		Fax Number:	Office Contact:
REV/HCPCS Code(s) and Number of Days/Units Requested			
REV/HCPC Code(s):		Number of days/units:	
Service request start date:	Projected length of stay:	Transition of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No	Continuation of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No

(continued)

## Diagnosis – Code and Description

Primary diagnosis:

Secondary diagnosis:

Medical diagnoses:

Are the requested services ordered by court?  Yes  No

If yes, please submit a copy of the court order and all supporting documentation.

## Clinical Details

Current symptoms and behaviors:

Is there a trigger event identified?  Yes  No If yes, please describe:

Is member motivated for treatment?  Yes  No

Is transportation available?  Yes  No

## Current Risks

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

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 non-suicidal self-injury  Yes  No (if yes, describe below) Check:  SI  HI

If above checked yes, please describe:

Date of most recent attempt or non-suicidal self-injury:

Prior serious attempt non-suicidal self-injury  Yes  No (if yes, describe below)

Check:  SI  HI

If above checked yes, please describe:

## Substance Abuse/Comorbidity

Does the member have a current Substance Use Disorder?  Yes  No

Is the member currently intoxicated?  Yes  No

If yes, please list substance(s) used:

Is the member currently experiencing withdrawal symptoms?  Yes  No

If yes, please list substance(s) used:

**Please check off all withdrawal symptoms the member is experiencing.**

Hand tremors  Impaired attention/memory  Psychomotor agitation

Sweating/Weakness  Nausea/Vomiting  Anxiety/Irritability

Nystagmus  Fluctuating vital signs  Changes in Mood/Personality

Insomnia  Vital signs:

Has member been medically cleared?  Yes  No

## 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 member currently receiving Outpatient services?  Yes  No

Any previous Inpatient, Residential/Rehab or IOP treatment?  Yes  No

Level of Care	Name or Provider/Facility	Dates	Successful
Inpatient			<input type="checkbox"/> Yes <input type="checkbox"/> No
Residential			<input type="checkbox"/> Yes <input type="checkbox"/> No
IOP			<input type="checkbox"/> Yes <input type="checkbox"/> No
PHP			<input type="checkbox"/> Yes <input type="checkbox"/> No
Outpatient			<input type="checkbox"/> Yes <input type="checkbox"/> No
Intensive Community-Based Treatment			<input type="checkbox"/> Yes <input type="checkbox"/> No

If treatment was not successful, please explain:

Please explain why the member cannot be managed safely in a less intensive level of care.

## Support Systems & Performance

Relationship/Supports (Identify issues/concerns? Is support available? Is support substance-free?)

What are the environmental/community stressors and/or supports that contribute to the member's clinical status?

Role performance school/work issues/concerns:

Describe the member/family engagement in treatment:

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

Is the member at risk of legal intervention or out-of-home placement?  Yes  No (describe):


## 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
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any medication contraindications? If yes, please describe:

Discharge plan upon admission:

## Attachments

  Current Treatment Plan  Biopsychosocial Assessment  Court Order  Psychiatric Report  
 Other:

## Continued Stay Reviews

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the past week that support the need for partial hospitalization or intensive outpatient services. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.

Continued symptoms/behaviors:

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

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

Symptom	Scale	Description
Functioning	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Complete assignments	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Cravings/preoccupation with substances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Ability to follow instructions	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Perform ADLs	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Drug-seeking behaviors	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Withdrawal symptoms	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	

Types of services offered	Total number of sessions attended	Total number of sessions missed	Member cooperative with treatment?	Please provide an explanation of any 'no' responses
Individual Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Use Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric Interventions			<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
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any medication contraindications? If yes, please describe:

Detail any updates or changes to the discharge plan:

## Attachments

-  Current Treatment Plan
  Biopsychosocial Assessment
  Court Order
  Psychiatric Report
  Other: