Behavioral Health Service Request Form

Routine Outpatient Services

Medicare

Please submit to the dedicated fax line below.

Arizona: **1-855-713-0593**	Kentucky: **1-888-365-5676**
Florida: **1-855-710-0168**	New Jersey: **1-888-339-2677**
Hawaii: **1-888-881-8225**	New York: **1-855-713-0589**
Connecticut, Maine, North Carolina: **1-888-365-5607**	Texas: **1-855-671-0259**
Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: **1-855-710-0160**	
Illinois, Iowa, Michigan, Missouri, Washington: **1-855-713-0593**	
Georgia: Medicare Only Members **1-877-892-8213**, Dual Eligible Members **1-855-292-0233**	

Place of Service:
☐ 11-Office ☐ 12-Home ☐ 13-Assisted-Living Facility ☐ 14-Group Home ☐ 20-Urgent Care Facility
☐ 22-On Campus–Outpatient Hospital ☐ 33-Custodial Care Facility ☐ 50-Federally Qualified Health Center
☐ 53-Community Mental Health Center ☐ 57-Non-residential Substance Abuse Treatment Facility
☐ 71-Public Health Clinic ☐ 72-Rural Health Clinic ☐ 99-Other place of service not identified above

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:

Facility/Agency Information

Name:	Facility ID:	NPI Number:
Street Address:	City, State:	ZIP:
Phone Number:	Fax Number:	Office Contact:
Are all units exhausted? ☐ Yes ☐ No If No, indicate amount used:		

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Service type requested	List REV/CPT/HCPS code(s)	Requested start date	Requested number of units (not to exceed 3 months)

Diagnosis – Code and Description

Primary diagnosis:

Secondary diagnosis:

Medical diagnoses:

Treatment Phase: Initiation (0-3 months): ☐ Continuation (3-6 months): ☐ Stabilization/Maintenance (over 6 months): ☐

Are services requested court-ordered? ☐ Yes ☐ No

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

Risk Factors and Symptoms

Please describe the member's baseline behavior:

Inpatient admissions for behavioral health/substance abuse treatment?

☐ Past 12 months ☐ More than 12 months ago ☐ Never

Current Severity Rating

Functional Area	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others	☐	☐	☐	☐	
Impairment of psychological functioning	☐	☐	☐	☐	
Impairment of social functioning (family/school/work)	☐	☐	☐	☐	
Impairment of physical functioning	☐	☐	☐	☐	
Impairment in support systems	☐	☐	☐	☐	
Other (list)	☐	☐	☐	☐	

If substance abuse identified please provide details:

Name of substance used	Date of first use	Frequency of use	Date of last use

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Treatment

Functional Area	Narrative explaining treatment interventions in each functional area of concern:
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment of social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	

Discharge Goal

Functional Area	Narrative describing discharge goals for each functional area of concern:
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment of social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	
Discharge plan (date)	

Adherent to therapy? ☐ Yes ☐ No	Adherent to medications? ☐ Yes ☐ No
Please list rationale for additional therapy sessions:	
Has the member made progress in treatment? ☐ Yes ☐ No If yes, please describe: If no, how has the treatment plan been modified accordingly?	
Does member have access to competent and available supports? ☐ Yes ☐ No Please explain:	
Does the member have transportation to and/or from services? ☐ Yes ☐ No	

*****Please submit a copy of the member's most recent Treatment Plan.**