

Behavioral Health Service Request Form



Routine Outpatient Services

Medicare

Please submit to the dedicated fax line below.

Florida: **1-855-710-0168**

Kentucky: **1-888-365-5676**

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, 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: <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:
Are all units exhausted? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, indicate amount used:				

(continued)

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of psychological functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of social functioning (family/school/work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment in support systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If substance abuse identified please provide details:

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

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.**