WellCare
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

Inpatient, Sub-acute, and CSU Services

Florida Medicaid
Call for Pre-certification of Admissions
1-866-334-7927
Please Submit to the Dedicated Fax Line Below
1-855-713-0197

	Retro Request	Please indicate if the services are completed and the member is no longer in active Inpatient care. Please submit the member record for review.
Level of Care:	☐ Inpatient ☐ Sub-acute ☐ CSU	
Place of Service:	☐ 21 - Inpatient Hospital ☐ 51 - Inpatient Psychiatric Hospital ☐ 53 - Community Mental Health Center	
Please contact WellCare 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 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	

FACILITY/AGENCY INFORMATION					
Name		Facility ID		NPI Number	
Street Address		City, State		ZIP	
Phone Number		Fax Number		Office Contact	

SERVICE TYPE REQUESTED			
If services requested are for Subacute or Crisis Stabilization Unit please include REV/HCPS Code			
Crisis Stabilization Unit			
Extended Care/ Sub-acute Unit			
Service Request Start Date:	Projected Length of Stay:	Transition of Care Yes No	Continuation of Care ☐ Yes ☐ No

DIAGNOSIS – Code and Description			
Primary Diagnosis		R/O	
Secondary Diagnosis		R/O	
Medical Diagnosis			

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

RATIONALE for REQUEST

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)	☐ 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	Date of most recent attempt:

If above checked yes, please describe:

Prior serious attempt or non-suicidal self-injury:	☐ Yes ☐ No (if yes, describe below)	Check: ☐ SI ☐ HI	Date of attempt:

If checked yes above, please describe:

CURRENT IMPAIRMENTS

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

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

Mood Disturbance (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
Impulsive/recklessness/aggressive	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Activities of daily living	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Weight change associated with Behavioral Health diagnosis ☐ gain ☐ loss lbs. in last three 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: (describe)	

Current living situation: ☐ homeless ☐ independent ☐ family ☐ foster home ☐ incarcerated ☐ other

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:

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

Name of Current Provider / Facility	Dates:	Compliant:
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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

Name of Provider / Facility:	Dates:	Compliant:
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No
		Yes No

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication:	Dosage:	Frequency:	Compliant:
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
Are there any medication contraindications? 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?

Describe the member/family engagement in treatment:

Expected Discharge date:	

Detail the discharge plan:

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Staywell A WellCare Company
Children's Medical Services Health Plan Operated by WellCare