WellCare
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

Detox and Substance Abuse Rehab

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

Level of Care:	☐ Detox ☐ Substance Abuse Rehab ☐ Halfway House
Place of Service:	☐ 14 - Group Home ☐ 16 - Temporary Lodging ☐ 21 - Inpatient Hospital ☐ 51 - Inpatient Psychiatric Hospital ☐ 53 - Community Mental Health Center ☐ 56 - Psychiatric Residential Treatment Center

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	RE/HCPCS Code(s)			
Service Type:	**REV/HCPS Code:**			
Detox				
Rehab				
Service Request Start Date:	**Projected Length of Stay:**	**Original Admission Date (if different from Start Date Requested):**	**Transition of Care** Yes No	**Continuation of Care** Yes No

DIAGNOSIS – Code and Description			
Primary Diagnosis			
Secondary Diagnosis			
Medical Diagnosis			
Are services requested court ordered? ☐ Yes ☐ No *If yes please submit a copy of the court order and all supporting documentation*			
Current CIWA Score: (if applicable)	**COW Score: (if applicable)**	**Current ASAM Dimension Scores: (if applicable)**	

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INITIAL REVIEW REQUESTS (See Continued Stay Review for Concurrent Reviews)	
PRESENTING PROBLEM	
Date Problem Began:	**Duration:**

Presenting problem to be addressed by treatment plan:

Is member currently intoxicated? ☐ Yes ☐ No

Is member currently experiencing withdrawal symptoms? ☐ Yes ☐ No

Does the member have a history of delirium tremens or withdrawal seizures? ☐ Yes ☐ No

If yes, please describe:

Is there a trigger event identified? ☐ Yes ☐ No **Please describe:**

Substances Used in the Past Year:	Frequency of Use:	Amount Used:	Last Use:

Please check off all withdrawal symptoms the member is experiencing:

Psychological/Physical				Changes in mood/personality (behavior)	
	Hand Tremors		Impaired attention /memory		Psychomotor agitation
	Sweating/Weakness		Nausea/Vomiting		Anxiety/Irritability
	Nystagmus		Fluctuating vital signs		Muscle/Bone/Joint Aches
	Insomnia		Stomach Cramps		Vital Signs:
Has member been medically cleared? ☐ Yes ☐ No					

CURRENT IMPAIRMENTS

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed
Check the current level of impairment for each category and provide a brief description:

Symptom:	Scale:	Description:	Symptom:	Scale:	Description:
Depressed Mood	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Substance Abuse / Dependence	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Nausea and Vomiting	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Agitation	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Tremor	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Generalized Anxiety	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Paroxysmal Sweats	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Visual Disturbances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	

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Unstable Vital Signs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Memory Impairment	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Delusions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Impaired Judgement	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Tactile Disturbances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Headache, fullness in Head	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Auditory Disturbances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Orientation and Clouding of Sensorium	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Socially Withdrawn/Isolating	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Interpersonal Conflict (hostile, intimidating)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Poor Impulse Control	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Cravings/Preoccupation with Substances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Drug Seeking Behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Work/School Problems	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	

Suicidal/Homicidal: ☐ Ideation ☐ Plan ☐ Means (Include previous attempts and dates)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Hallucinations: ☐ Auditory ☐ Visual ☐ Command (Include examples and dates)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

CURRENT / PREVIOUS TREATMENT

Indicate if any of the following are involved in the member's care and list Provider?

Psychiatrist: Yes No **Provider:** **PCP:** Yes No **Provider:**
Integrated Health Home: Yes No **Provider:**

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, PHP or IOP treatment? Yes No

Level of Care:	Name or Provider / Facility:	Dates:	Successful:
Inpatient / Detox:			☐ Yes ☐ No
Substance Abuse Rehab:			☐ Yes ☐ No
IOP / PHP:			☐ Yes ☐ No
Outpatient:			☐ Yes ☐ No

If treatment was not successful, please explain:

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

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

SUPPORT SYSTEMS & PERFORMANCE

Relationship/Supports (identify issues/concerns; Is support available / Is support substance free?)

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What are the environmental/community stressors and/or supports that contribute to the member's clinical status?
Describe the member/family engagement in treatment:
Is the member at risk of legal intervention or out-of-home placement? ☐ Yes ☐ No (describe)
Role performance school/work:

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:				

Detail the expected discharge plan:

ATTACHMENTS

☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other

CONTINUED STAY REVIEW

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the last week that support the need for residential care. 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:

Current CIWA Score: (if applicable)	COW Score: (if applicable)	Current ASAM Dimension Scores: (if applicable)	

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

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Symptom:	Scale:	Description:	Symptom:	Scale:	Description:
Functioning	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Ability to follow instructions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Complete assignments	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Perform ADLs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Cravings/preoccupation with substances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Drug-seeking behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Withdrawal symptoms	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A				

Types of services offered	Total number of sessions attended	Total number of sessions missed	Member Cooperative with Treatment?	Please provider an explanation of any "NO" responses
Individual Therapy			Yes No	
Group Therapy			Yes No	
Substance Abuse Counseling			Yes No	
Family Therapy			Yes No	
Psychiatric Interventions			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:			

Detail changes to the discharge plan:

ATTACHMENTS

☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other