WellCare®
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

PHP and IOP Services as Covered

Please Submit to the Dedicated Fax Line Below
Florida Medicaid
1-855-713-0197

Place of Service	☐ 11 - Office ☐ 22 - Outpatient Hospital ☐ 52 - Psychiatric Facility-Partial Hospitalization ☐ 53 - Community Mental Health Center
Treatment Focus	☐ Mental Health ☐ Substance Use Disorder ☐ Dual Diagnosis

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	REV/HCPCS Code(s) and Number of Days/Units Requested		
PHP	REV/HCPC Code (s):	Number of Days/Units:	
IOP	REV/HCPC Code (s):	Number of Days/Units:	
Service Request Start Date:	Projected Length of Stay:	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.*

CLINICAL DETAILS
Current Symptoms and Behaviors:
Is there a trigger event identified? ☐ Yes ☐ No Please describe:

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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/Co-Morbidity

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, PHP or IOP treatment? Yes No

Level of Care:	Name or Provider / Facility:	Dates:	Successful:
Inpatient:			☐ Yes ☐ No
Residential:			☐ Yes ☐ No
IOP / PHP:			☐ Yes ☐ No
Outpatient:			☐ Yes ☐ No
Intensive Community Based Treatment:			☐ Yes ☐ No

If treatment was not successful, please explain:

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

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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:
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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 last 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:

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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:	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 provide an explanation of any "NO" responses
Individual Therapy			Yes No	
Group Therapy			Yes No	
Substance Abuse			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 any updates or changes to the discharge plan:

ATTACHMENTS

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

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