

Behavioral Health Service Request Form

Detox and Substance Abuse Rehab

Georgia Medicare
Call for Pre-certification of Admissions
1-855-538-0454
Please Submit to the Dedicated Fax Line Below
Medicare Only Members: 1-877-892-8213
Dual Eligible Members (Members with Medicare & Medicaid Policies): 1-855-292-0233
Discharge Planning: 1-855-776-9464

Level of Care:	<input type="checkbox"/> Detox <input type="checkbox"/> Substance Abuse Rehab
Place of Service:	<input type="checkbox"/> 21- Inpatient Hospital <input type="checkbox"/> 51- Inpatient Psychiatric Hospital <input type="checkbox"/> 55- Residential Substance Abuse Treatment Facility <input type="checkbox"/> 56- Psychiatric Residential Treatment Center

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

SERVICE TYPE REQUESTED	REV/HCPCS Code(s)
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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: <input type="checkbox"/> Yes <input type="checkbox"/> No	Continuation of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No
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DIAGNOSIS – Code and Description			
Primary Diagnosis			
Secondary Diagnosis			
Medical Diagnoses			
Are services requested ordered by court? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please submit a copy of the court order and all supporting documentation.</i>			
Current CIWA Score: (if applicable)	COW Score: (if applicable)	Current ASAM Dimension: Scores (if applicable)	

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 the member currently intoxicated? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
Is the member currently experiencing withdrawal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
Does the member have a history of delirium tremens or withdrawal seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No																															
If yes, please describe:																															
Is there a trigger event identified? <input type="checkbox"/> Yes <input type="checkbox"/> No Please describe:																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">Substance</th> <th style="width: 15%;">Method</th> <th style="width: 15%;">Amount</th> <th style="width: 15%;">Frequency</th> <th style="width: 15%;">First Used</th> <th style="width: 15%;">Last Used</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>		Substance	Method	Amount	Frequency	First Used	Last Used																								
Substance	Method	Amount	Frequency	First Used	Last Used																										

Please check all withdrawal symptoms the member is experiencing:

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

CURRENT IMPAIRMENTS					
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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	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Substance Abuse/ Dependence	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	

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Nausea and Vomiting	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Agitation	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Tremor	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Generalized Anxiety	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Paroxysmal Sweats	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Visual Disturbances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Unstable Vital Signs	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Memory Impairment	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Delusions	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Impaired Judgement	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Tactile Disturbances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Headache, Fullness in Head	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Auditory Disturbances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Orientation and Clouding of Sensorium	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Socially Withdrawn/Isolating	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Interpersonal Conflict (hostile, intimidating)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Poor Impulse Control	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Cravings/Preoccupation with Substances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Drug Seeking Behaviors	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Work/School Problems	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Suicidal/Homicidal: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means (Include previous attempts and dates)				<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
Hallucinations: <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Command (Include examples and dates)				<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A																					
CURRENT/PREVIOUS TREATMENT																									
Indicate if any of the following are involved in the member's care and list Provider:																									
Psychiatrist: <input type="checkbox"/> Yes <input type="checkbox"/> No Provider: _____ PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No Provider: _____																									
Integrated Health Home: <input type="checkbox"/> Yes <input type="checkbox"/> No Provider: _____																									
If yes, when was the member last seen and what services are being rendered?																									
Is the member currently receiving Outpatient services? <input type="checkbox"/> Yes <input type="checkbox"/> No																									
Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No																									
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Level of Care</th> <th style="width: 40%;">Name or Provider / Facility</th> <th style="width: 20%;">Dates</th> <th style="width: 20%;">Successful</th> </tr> </thead> <tbody> <tr> <td>Inpatient / Detox:</td> <td></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Substance Abuse Rehab:</td> <td></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>IOP/PHP:</td> <td></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Outpatient:</td> <td></td> <td></td> <td style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table>						Level of Care	Name or Provider / Facility	Dates	Successful	Inpatient / Detox:			<input type="checkbox"/> Yes <input type="checkbox"/> No	Substance Abuse Rehab:			<input type="checkbox"/> Yes <input type="checkbox"/> No	IOP/PHP:			<input type="checkbox"/> Yes <input type="checkbox"/> No	Outpatient:			<input type="checkbox"/> Yes <input type="checkbox"/> No
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IOP/PHP:			<input type="checkbox"/> Yes <input type="checkbox"/> No																						
Outpatient:			<input type="checkbox"/> Yes <input type="checkbox"/> No																						
If treatment was not successful, please explain:																									
Please explain why the member cannot be managed safely in a less intensive level of care:																									

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

Name of Provider/Facility	Dates	Compliant
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

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?

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
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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CONTINUED STAY REVIEW

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the past 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:

Symptom	Scale	Description	Symptom	Scale	Description
Functioning	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Ability to follow instructions	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Complete assignments	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Perform ADLs	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Cravings/preoccupation with substances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Drug-seeking behaviors	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Withdrawal symptoms	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A				

Types of services offered	Total number of sessions attended	Total number of sessions missed	Is member cooperative with treatment?	Please provide an explanation of any 'no' responses
Individual Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Abuse Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric Interventions			<input type="checkbox"/> Yes <input type="checkbox"/> No	

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Compliant
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any medication contraindications? If yes, please describe:

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Detail changes to the discharge plan:

ATTACHMENTS

<input type="checkbox"/> Current Treatment Plan	<input type="checkbox"/> Incident Report(s)	<input type="checkbox"/> Psychological Report	<input type="checkbox"/> Psychiatric Report	<input type="checkbox"/> Other:
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