

Behavioral Health Service Request Form

PHP Services as Covered

Please Submit to the Dedicated Fax Line Below	
Medicare	
Arizona 1-855-713-0593; AZ Liberty 1-866-246-9832	Kentucky 1-888-365-5676
Florida 1-855-710-0168	New Jersey 1-888-339-2677
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, Indiana, Missouri, Michigan, New Hampshire, Ohio, Rhode Island, Vermont, Washington: 1-855-713-0593	

Place of Service	<input type="checkbox"/> 22-Outpatient Hospital <input type="checkbox"/> 52-Psychiatric Facility-Partial Hospitalization <input type="checkbox"/> 53-Community Mental Health Center
Treatment Focus	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Dual Diagnosis

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

REV/HCPCS Code(s) and Number of Days/Units Requested			
REV/HCPC Code (s) :		Number of Days/Units :	
Service Request Start Date:	Projected Length of Stay:	Transition of Care:	Continuation of Care:
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSIS – Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnoses	

Are the requested services ordered by court? 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please describe:			
Is member motivated for treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Is transportation available?
			<input type="checkbox"/> Yes <input type="checkbox"/> No

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CURRENT RISKS

Check the risk level for each category and check all boxes that apply.

Risk to self (SI)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	With <input type="checkbox"/> ideation <input type="checkbox"/> intent <input type="checkbox"/> plan <input type="checkbox"/> means
Risk to others (HI)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	With <input type="checkbox"/> ideation <input type="checkbox"/> intent <input type="checkbox"/> plan <input type="checkbox"/> means
Current serious attempt or non-suicidal self-injury	<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, describe below)	Check: <input type="checkbox"/> SI <input type="checkbox"/> HI

If above checked yes, please describe:

Date of most recent attempt or non-suicidal self-injury:

Prior serious attempt non-suicidal self-injury	<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, describe below)	Check: <input type="checkbox"/> SI <input type="checkbox"/> HI
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If above checked yes, please describe:

SUBSTANCE ABUSE/COMORBIDITY

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.

<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"/> Changes in Mood/Personality
<input type="checkbox"/> 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			<input type="checkbox"/> Yes <input type="checkbox"/> No
Residential			<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
Intensive Community-Based Treatment			<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.

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?

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
			<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:

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 past 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:

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	

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Withdrawal symptoms	<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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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			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Use 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:

Detail any updates or changes to the discharge plan:

ATTACHMENTS

<input type="checkbox"/> Current Treatment Plan	<input type="checkbox"/> Biopsychosocial Assessment	<input type="checkbox"/> Court Order	<input type="checkbox"/> Psychiatric Report	<input type="checkbox"/> Other:
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