WellCare
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

Routine Outpatient Services

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	☐ 11-Office ☐ 12-Home ☐ 13-Assisted-Living Facility ☐ 14-Group Home ☐ 20-Urgent Care Facility ☐ 22-On Campus–Outpatient Hospital ☐ 33-Custodial Care Facility ☐ 50-Federally Qualified Health Center ☐ 53-Community Mental Health Center ☐ 57-Non-residential Substance Abuse Treatment Facility ☐ 71-Public Health Clinic ☐ 72-Rural Health Clinic ☐ 99-Other place of service not identified above

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**	

Are all units exhausted? ☐ Yes ☐ No | **If No, indicate amount used:**

SERVICE TYPE REQUESTED	LIST REV/CPT/HCPS CODE(S)	REQUESTED START DATE	REQUESTED NUMBER OF UNITS (NOT TO EXCEED 3 MONTHS)

DIAGNOSIS – Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnoses	

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Treatment Phase: Initiation (0-3 months) : Continuation (3-6 months): Stabilization/Maintenance (over 6 months) :

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

RISK FACTORS AND SYMPTOMS

Please describe the member's baseline behavior:

	Past 12 months	More than 12 months ago	Never
Inpatient admissions for behavioral health/substance abuse treatment?	☐	☐	☐

Current Severity Rating					
Functional Area	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others	☐	☐	☐	☐	
Impairment of psychological functioning	☐	☐	☐	☐	
Impairment of social functioning (family/school/work)	☐	☐	☐	☐	
Impairment of physical functioning	☐	☐	☐	☐	
Impairment in support systems	☐	☐	☐	☐	
Other (list)	☐	☐	☐	☐	

If substance abuse identified please provide details:

Name of substance used	Date of first use	Frequency of use	Date of last use

Treatment	
Functional Area	**Narrative explaining treatment interventions in each functional area of concern:**
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	

Discharge Goal	
Functional Area	**Narrative describing discharge goals for each functional area of concern:**
Risk of harm to self or others	
Impairment of psychological functioning	

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Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	
Discharge plan (date)	

Adherent to therapy?	☐ Yes ☐ No	Adherent to medications?	☐ Yes ☐ No

Please list rationale for additional therapy sessions:

Has the member made progress in treatment? ☐ **Yes** ☐ **No**
If yes, please describe:
If no, how has the treatment plan been modified accordingly?

Does member have access to competent and available supports? ☐ **Yes** ☐ **No** **Please explain:**

Does the member have transportation to and/or from services? ☐ **Yes** ☐ **No**

***** Please submit a copy of the member's most recent Treatment Plan.**