Behavioral Health Service Request Form

Partial Hospitalization Program and Intensive Outpatient Program as Covered

Please Submit to the Dedicated Contract Fax Line Below

Medicaid			
Nebraska 1-855-279-3683			
Place of Service	11 - Office 53 - Community Mental Health Center	22 - Outpatient Hospital	52 - Psychiatric Facility-Partial Hospitalization
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:			
Is member motivated for treatment?	Yes No	Is Transportation available?	Yes No

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CURRENT RISKS

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

Risk to self (SI)		With	ideation	intent	plan	means
Risk to others (HI)		With	ideation	intent	plan	means
Current serious attempt or non-suicidal self-injury	(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/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:

	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, who is the Psychiatrist treating the member?

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 and/or 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:

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 SERVICE REVIEW

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:

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 NA		Ability to follow instructions	0 ☐ 1 ☐ 2 ☐ 3 NA	
Complete assignments	0 1 2 3 NA		Perform ADLs	0 ☐ 1 ☐ 2 ☐ 3 NA	
Cravings/preoccupation with substances	0 1 2 3 NA		Drug-seeking behaviors	0 ☐ 1 ☐ 2 ☐ 3 NA	
Withdrawal symptoms	0 1 2 3 NA				

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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 any updates or changes to the discharge plan:

ATTACHMENTS

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