WellCare Health Plans | Heritage Health

Behavioral Health Service Request Form

Psychiatric Residential Treatment (24/7 Services) Request Form

Please Submit to the Dedicated Fax Line Below

Medicaid
Nebraska 1-877-849-5071

Place of Service	14 – Therapeutic Group Home 16 – Temporary Lodging 21 – Inpatient Hospital 51 – Inpatient Psychiatric Facility 53 – Community Mental Health Center 56 - Psychiatric Residential Treatment Center

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		List REV/ HCPCS Code(s)		
Residential: Mental Health				
Effective Date Requested:	Projected Length of Stay:	Original Admission Date (if different from Effective Date):	Transition of Care Yes No	Continuity of Care Yes No

DIAGNOSIS Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	

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

INITIAL REVIEW REQUESTS (For Continued Stay Review go to next page)					
Presenting problem to be addressed by treatment plan:					
Date problem began		Duration		Is member under a psychiatrist's care?	Yes No

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Is member currently inpatient?	Yes No	If yes, what facility is member admitted to and what is the current length of stay?	

Does the member have any chronic illnesses that require staff supervision?
If yes, indicate the illness, the severity and how staff time and resources are utilized.

Has the member experienced any acute illnesses, medical complications or medical hospitalizations during the last three months?

Does the member have a current Substance Use Disorder? Yes No

If yes, please list substance(s) used :

Substances Used in the Past Year:	Frequency of Use:	Amount Used:	Last Use:

Has the member exhausted all lower levels of care? Yes No

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

CURRENT/PREVIOUS TREATMENT

Is member currently receiving Outpatient services?
Yes No
If yes:

Name of Provider / Facility:	Dates:	Compliant:
		Yes No
		Yes No
		Yes No
		Yes No

Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment? Yes No

Level of Care:	Name or Provider / Facility:	Dates:	Compliant:
Inpatient:			Yes No
Residential:			Yes No
Partial Hospitalization:			Yes No
IOP:			Yes No
Intensive Community-Based Treatment:			Yes No

If treatment / placement 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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MENTAL STATUS EXAM AND SYMPTOMS

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	0 1 2 3 N/A		Substance Abuse / Dependence	0 1 2 3 N/A	
Self-Mutilation	0 1 2 3 N/A		Substance Use Withdrawal	0 1 2 3 N/A	
Impaired Attention/Concentration	0 1 2 3 N/A		Cravings	0 1 2 3 N/A	
Impulsive/Dangerous Behaviors	0 1 2 3 N/A		Cruelty to animals	0 1 2 3 N/A	
Work/School/ADL Problems	0 1 2 3 N/A		Memory Impairment	0 1 2 3 N/A	
Delusions	0 1 2 3 N/A		Impaired Judgement	0 1 2 3 N/A	
Eating Disorders	0 1 2 3 N/A		Lack of Insight	0 1 2 3 N/A	
Fire Setting	0 1 2 3 N/A		Generalized Anxiety	0 1 2 3 N/A	
Obsession/Compulsion	0 1 2 3 N/A		Sexually Inappropriate/Aggressive	0 1 2 3 N/A	
Illegal Activities	0 1 2 3 N/A				

Suicidal/Homicidal Ideation Plan Provide details including previous attempts and dates:	0 1 2 3 N/A
Hallucinations: Auditory Visual Command Provide details including previous examples and dates:	0 1 2 3 N/A

SUPPORT SYSTEMS & PERFORMANCE

Relationships/Supports (issues / concerns; Is support available / Is support substance free?)
Please provide details:

Role performance school/work issues/concerns:
Please provide details:

Current living situation? homeless independent family foster home incarcerated other:

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:

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ATTACHMENTS

Current Treatment Plan	Incident Report(s)	Psychological Report	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 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:

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	

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 Counseling			Yes No	
Group Counseling			Yes No	
Psychiatric interventions			Yes No	
Family Counseling			Yes No	
Substance Use Counseling			Yes No	
Sexual Reactive Treatment			Yes No	
Sexual Offender Treatment			Yes No	
Other services			Yes No	

Has the member’s behavior necessitated a significant change in treatment, medication, or supervision? Yes No

If yes, please specify the changes (use a separate sheet if necessary):

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:

Method of Intervention	Frequency	Has the use of these methods become more frequent? If so, please explain
Use of Time-out		
Physical management/Restraint (does not include escorts or assists)		
Calls for outside assistance (law enforcement, non-agency staff, etc.)		
Other		

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Updates to Discharge Plan:	Expected discharge date:

Current Treatment Plan				
Current Treatment Plan	Incident Report(s)	Psychological Report	Psychiatric Report	Other:

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