



Behavioral Health Service Request Form

Detox and Substance Abuse Rehab

Medicare

Please submit to the dedicated fax line below.	
Florida: 1-855-710-0167	Kentucky: 1-888-365-5615
Hawaii: 1-888-890-8219	New York: 1-855-713-0588
Connecticut, Maine, North Carolina: 1-888-365-3233	Texas: 1-855-671-0258
Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: 1-855-710-0159	
Illinois, Michigan, Missouri, Washington: 1-855-713-0592	
Georgia: Medicare Only Members 1-877-892-8213 , Dual Eligible Members 1-855-292-0233	

Level of Care:
 Detox Substance Abuse Rehab

Place of Service:
 21-Inpatient Hospital 55-Residential Substance Abuse Treatment Facility
 51-Inpatient Psychiatric Hospital 56-Psychiatric Residential Treatment Center

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:

(continued)

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)

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

Diagnosis – Code and Description

Primary diagnosis:		
Secondary diagnosis:		
Medical diagnoses:		
Are services requested ordered by court? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please submit a copy of the court order and all supporting documentation.		
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 member currently intoxicated? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is 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 If yes, please describe:					
Substance	Method	Amount	Frequency	First Used	Last Used

(continued)

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 member been medically cleared? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Current Impairments

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
Depressed Mood	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Nausea and Vomiting	<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	
Paroxysmal Sweats	<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	
Delusions	<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	
Auditory Disturbances	<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	
Poor Impulse Control	<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	
Substance Abuse/Dependence	<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	
Generalized Anxiety	<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	
Memory Impairment	<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	
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	
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	
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	
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	
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: Yes No Provider:

PCP: Yes No Provider:

Integrated Health Home: Yes No Provider:

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/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

If treatment was not successful, please explain:

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

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

Name or 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 and 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? Yes No

If yes, please describe:

Detail the expected discharge plan:

Attachments

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

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
Functioning	<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	
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	
Withdrawal symptoms	<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	
Perform ADLs	<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	

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 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? Yes No

If yes, please describe:

Detail changes to the discharge plan:

Attachments

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