

Behavioral Health Service Request Form



Inpatient, Subacute and CSU Services

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		
Retro Request – Please indicate if the services are completed and the member is no longer in Inpatient care. Please submit the member record for review.		
Level of Care: <input type="checkbox"/> Inpatient <input type="checkbox"/> Subacute <input type="checkbox"/> CSU		
Place of Service: <input type="checkbox"/> 21-Inpatient Hospital <input type="checkbox"/> 51-Inpatient Psychiatric Hospital <input type="checkbox"/> 53-Community Mental Health Center		
Please contact Wellcare for authorization of Inpatient services at the time of admission or on the next business day following admission to a psychiatric Inpatient program. After the initial authorization determination, providers must perform concurrent review for any additional Inpatient days authorized. This form should be used by providers to ensure our review process will be as quick and efficient as possible.		
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:

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

Reason for Admission

Presenting problem to be addressed by treatment plan:

Date problem began:	Duration:	Is member under the care of a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is member currently inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the current length of stay?
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Is member currently receiving Outpatient services? Yes No
If yes:

Name of 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

I acknowledge that I am required to send a report of the member's admission to inpatient services to their PCP, and I will update their PCP quarterly.

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Current Risk

Risk level scale: 0 = none; 1 = mild, ideation only; 2 = moderate, ideation with either a plan or history of attempts; 3 = severe, ideation AND plan, with either intent or means.

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, please describe:	Check: <input type="checkbox"/> SI <input type="checkbox"/> HI Date of attempt:	
Prior serious attempt or non-suicidal self-injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:	Check: <input type="checkbox"/> SI <input type="checkbox"/> HI Date of attempt:	

Current Impairments

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed

Check the impairment level for each category and please provide brief description of any severe (3) impairments.

Mood Disturbance (depression, mania)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Anxiety	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Psychosis	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Thinking/cognition/memory	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Impulsive/recklessness/aggressive	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Activities of daily living	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Weight change associated with behavioral health diagnosis <input type="checkbox"/> gain <input type="checkbox"/> loss lbs. in past three months	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Medical/physical conditions	<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	
Job/school performance	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Social/marital/family problems	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Legal	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Stressors	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Orientation/alertness/awareness	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	

Current/Previous Treatment

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?

History of hospitalization in the past year? Yes No

Name of Facility	Dates

(continued)

Is a therapist currently involved in the members care? Yes No

Name of Current 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

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

Name of 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

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

Are there any medication contraindications? Yes No

If yes, please describe:

Additional Clinical Information

Is the member at risk of legal intervention or out-of-home placement? Describe:

Describe the overall risk of harm (to self or others):

What are the environmental/community stressors and/or supports that contribute to the member's clinical status?

Support System (describe):

Describe the member/family engagement in treatment:

Current living situation: Homeless Independent Family Foster home Incarcerated
 Other:

Detail the discharge plan: