Florida Medicaid and Healthy Kids Behavioral Health Services Request Form
FOR: Residential, SIPP, and Specialized Therapeutic Services

Please submit completed form via fax to: 1-855-713-0587

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan at least seven (7) days prior to the date the requested services will be performed.
☐	**Expedited Request**	***Can only be requested with physician signature.*** By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request _____ Date Signed _____

Service Type Requested	***List REV/CPT/HCPCS Code(s)***
Residential	
State Inpatient Psychiatric Program (SIPP)	
Specialized Therapeutic Foster Care	
Therapeutic Group Home	

Service Request Start Date:

MEMBER INFORMATION

Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**WellCare ID Number**		**Gender**	☐ **Female** ☐ **Male**
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.			
PRIMARY DIAGNOSIS					

RESIDENCE/AGENCY BILLING INFORMATION

Name		**Facility ID**		**NPI Number**	
Street Address		**City, State**		**Zip**	
Phone Number		**Fax Number**		**Office Contact**	

RESIDENCE LOCATION INFORMATION (IF DIFFERENT THAN BILLING DATA)

Name and Address of Residence	**Residence Phone Number:**
Residence Fax Number:	**Residence Contact Person:**

RATIONALE for REQUEST

CURRENT RISKS

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; na = not assessed.

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

CURRENT Risk to self (suicide or other harmful behavior)	☐ **Yes** ☐ **No**	**Describe:**
CURRENT Risk to others (HI and aggression)	☐ **Yes** ☐ **No**	**Describe:**
HX of serious suicide attempts	☐ **Yes** ☐ **No**	**Describe:**

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CURRENT IMPAIRMENTS	
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; na = not assessed Check the impairment level for each category.	
Mood Disturbance (depression, mania)	__ 0 __ 1 __ 2 __ 3 __ na
Anxiety	__ 0 __ 1 __ 2 __ 3 __ na
Psychosis	__ 0 __ 1 __ 2 __ 3 __ na
Thinking/cognition/memory	__ 0 __ 1 __ 2 __ 3 __ na
Impulsive/recklessness/aggressive	__ 0 __ 1 __ 2 __ 3 __ na
Activities of daily living	__ 0 __ 1 __ 2 __ 3 __ na
Weight change associated with Behavioral Health diagnosis ☐ gain ☐ loss _____ lbs in last three months	__ 0 __ 1 __ 2 __ 3 __ na
Medical/physical conditions	__ 0 __ 1 __ 2 __ 3 __ na
Substance abuse/dependence	__ 0 __ 1 __ 2 __ 3 __ na
Job/school performance	__ 0 __ 1 __ 2 __ 3 __ na
Social/marital/family problems	__ 0 __ 1 __ 2 __ 3 __ na
Legal	__ 0 __ 1 __ 2 __ 3 __ na
Stressors	__ 0 __ 1 __ 2 __ 3 __ na
Orientation/alertness /awareness	__ 0 __ 1 __ 2 __ 3 __ na
Supports	__ 0 __ 1 __ 2 __ 3 __ na
Job/school performance	__ 0 __ 1 __ 2 __ 3 __ na
Social/marital/family problems	__ 0 __ 1 __ 2 __ 3 __ na

ADDITIONAL DATA TO SUPPORT REQUEST

Please describe the behavioral health conditions and history that led to this residential request.

If the member is a minor: who has custody? Please provide a specific contact name and phone number

Please describe what clinical interventions will be provided by this service and why the member would benefit.

Please describe what skills and supports will need to be addressed to facilitate discharge.

Describe prior outpatient services (what/when/where), what worked and what did not, and barriers to completing treatment.

History of hospitalization/residential placements in the past year? ☐ **Yes** ☐ **No**

Name of Facility	Dates

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What are the environmental/community stressors and/or supports that contribute to the member's clinical status?
Describe the member/family engagement in treatment.
Where do you expect the member to go upon discharge and what barriers need to be addressed to facilitate that plan?
What are the current medical and psychiatric medications? (name, dose, frequency)

Primary Diagnoses		**R/O**	
Secondary Diagnoses		**R/O**	
Medical Problems			

Current Functional Assessment Score		**Highest Functional Assessment Score in Past Year**	

PLEASE SUBMIT CURRENT FARS-CFARS/PSYCHOLOGICAL/PSYCHIATRIC/BIO-PSYCHOSOCIAL ASSESSMENTS

****ADDITIONAL INFORMATION MAY BE REQUESTED***