Behavioral Health Service Request Form

Routine Outpatient Services

Florida Medicaid and Florida Healthy Kids
Florida – 1-855-713-0587

Prior Authorization is not required for the first 20 units of:
90832 Psychotherapy - 30 mins, 90834 Psychotherapy - 45 mins, 90837 Psychotherapy - 60 mins, 90846 Family Psychotherapy - without patient present, 90847 Family Psychotherapy - 45 min, 90849 Multiple-family group psychotherapy 90853 Group psychotherapy and **first 200 units of:** H2019 HQ, H2019 HR, H2019 HR-GT Group/ Individual/Family Therapy Services, H2019 HM, H2019 HN, H2019 HO TBOS Services, H2012, H2012 HF Day Treatment Services, H2017 Psychosocial Rehab Services, andT1017, T1017 HA, T1017 HK Targeted Case Management Services
Please note: Prior Authorization is required for all services provided by NON-PARTICIPATING PROVIDERS

Place of Service	☐ **11- Office** ☐ **12- Home** ☐ **13- Assisted Living Facility** ☐ **14- Group Home** ☐ **20- Urgent Care Facility** ☐ **22- On Campus Outpatient Hospital** ☐ **33- Custodial Care Facility** ☐ **50- Federally Qualified Health Center** ☐ **53- Community Mental Health Center** ☐ **57- Non-residential Substance Abuse Treatment Facility** ☐ **71- Public Health Clinic** ☐ **72- Rural Health Clinic** ☐ **99- Other place of service not identified above**

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.		**Housing**	

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/CPT/HCPS CODE(S)	REQUESTED NUMBER OF UNITS (NOT TO EXCEED A 3 MONTH PERIOD)

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DIAGNOSIS	
Primary Diagnosis	
Secondary Diagnosis	
Medical Problems	

Treatment Phase: Initiation (0-3 months): ☐ Continuation (3-6 months): ☐ Stabilization/Maintenance (over 6 months): ☐

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

RISK FACTORS AND SYMPTOMS

Please describe the member's baseline behavior :

	Past 12 months	More than 12 months ago	Never
Inpatient admissions for behavioral health/substance abuse treatment?	☐	☐	☐

Current Severity Rating					
Functional Area	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others	☐	☐	☐	☐	
Impairment of psychological functioning	☐	☐	☐	☐	
Impairment in social functioning (family/school/work)	☐	☐	☐	☐	
Impairment of physical functioning	☐	☐	☐	☐	
Impairment in support systems	☐	☐	☐	☐	
Other (list)	☐	☐	☐	☐	

If substance abuse identified, please provide details :

Name of substance used:	Date of first use:	Frequency of use:	Date of last use:

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Treatment	
Functional Area	**Narrative explaining treatment interventions in each functional area of concern:**
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	

Discharge Goal	
Functional Area	**Narrative describing discharge goals for each functional area of concern:**
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	
Discharge plan (date)	

Adherent to therapy?	☐ Yes ☐ No	Adherent to medications?	☐ Yes ☐ No

Please list rationale for additional therapy sessions:

Has the member made progress in treatment? ☐ **Yes** ☐ **No**
If yes, please describe:
If no, how has the treatment plan been modified accordingly?

Does member have access to competent and available supports? ☐ **Yes** ☐ **No** **Please explain:**

Does the member have transportation to and/or from services? ☐ **Yes** ☐ **No**

*****Please submit a copy of the member's most recent Treatment Plan**