Behavioral Health Service Request Form

Targeted Case Management (TCM)

Medicaid
Kentucky Fax # – 877-544-2007

Place of Service	☐ 11- Office ☐ 12- Home ☐ 53- Community Mental Health ☐ 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.		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	

REQUESTED START DATE	REQUESTED NUMBER OF UNITS (NOT TO EXCEED 3 UNITS)

DIAGNOSIS Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Problems	

ASAM Dimension Scores	CASII Score	ECSII Score	LOCUS Score

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

RATIONALE FOR REQUEST

Does the member receive medication management services? ☐ Yes ☐ No When was member last seen?

Medication:	Dosage:	Frequency:	Compliant:
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Are there any medication contraindications? If yes, please describe:

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WellCare Health Plans

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Summarize the care plan goals/interventions: (Leave blank if attaching a copy of the care plan.)

What will TCM services address in the next service period:

Response to services: (Please describe progress or lack of progress.)

Compliance with services: (If noncompliant, how will this be addressed?)

What is the Discharge Plan:

Expected Discharge Date:

RATIONALE FOR REQUEST

Circle the impairment level for each category and <u>give a brief description</u>.

Scale: 0=None; 1 = Mild; 2 = Moderate; 3 = Severe; N/A = Not Assessed

Category						
Risk of harm (i.e., S/I; self-harming behaviors; etc.):	**0**	**1**	**2**	**3**	**4**	**5**
Functional status (i.e., needs help with ADLs):	**0**	**1**	**2**	**3**	**4**	**5**
Comorbidities (i.e., S.A.; medical):	**0**	**1**	**2**	**3**	**4**	**5**
Environmental stressors (i.e., domestic violence; transportation issues):	**0**	**1**	**2**	**3**	**4**	**5**
Support in the environment: (Who are the supports?)	**0**	**1**	**2**	**3**	**4**	**5**
Response to treatment: (If minimal response, how is the treatment plan being adjusted to address?)	**0**	**1**	**2**	**3**	**4**	**5**
Acceptance and engagement: (Does member/caregiver identify need for treatment and participate?)	**0**	**1**	**2**	**3**	**4**	**5**

*****Please submit a copy of the following and any additional supporting documentation for medical necessity review:**
Initial Request – most recent assessment; service plan
Concurrent Request – updated service plan; contact log

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