

Behavioral Health Service Request Form

ACT Services Request Form

Please Submit to the Dedicated Contract Fax Line Below

Medicaid					
Kentucky 877-544-2007					
Place of Service <input type="checkbox"/> 11- Office <input type="checkbox"/> 12- Home <input type="checkbox"/> 22- Outpatient Hospital <input type="checkbox"/> 53- Community Mental Health 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	
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/HCPCS Code(s) and Number of Each Requested		
ACT Services CPT Codes Requested					
Service Request Start Date:		Service Request End Date:		Transition of Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Continuation of Care <input type="checkbox"/> Yes <input type="checkbox"/> No	
DIAGNOSIS					
Primary Diagnoses					
Secondary Diagnoses					
Medical Problems					
If request is for Mental Health please complete the following :					
Current GAF/CAFAS		Highest GAF/CAFAS in Past Year		Current Total LOCUS/CALOCUS Score (If applicable)	
RATIONALE for REQUEST					
Are services requested court ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes please submit a copy of the court order and all supporting documentation</i>					
Is a psychiatrist involved in the member's care? <input type="checkbox"/> Yes <input type="checkbox"/> No				When was member last seen?	
Presenting Problem: (describe)					
Ongoing Problem: (describe)					

Behavioral Health Service Request Form

ACT Services Request Form

Please Submit to the Dedicated Contract Fax Line Below

CURRENT IMPAIRMENTS	
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed	
Check the impairment level for each category and give a brief description.	
Risk of Harm	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Functional Status	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Co-Morbidities	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Environmental Stressors	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Support in the environment	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Response to treatment (if poor response; how is the treatment plan being adjusted to address)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Acceptance and engagement:	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A