

# Behavioral Health Service Request Form

## Routine Outpatient Services

Please Submit to the Dedicated Fax Line Below	
Medicare	
Arizona 1-888-834-8404	Kentucky 1-888-365-5676
Florida 1-855-710-0168	New Jersey 1-888-339-2677
Hawaii 1-888-881-8225	New York 1-855-713-0589
Connecticut, Maine, North Carolina: 1-888-365-5607	Texas 1-855-671-0259
Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: 1-855-710-0160	
Illinois, Indiana, Missouri, New Hampshire, Washington: 1-855-713-0593	

Place of Service	<input type="checkbox"/> 11- Office <input type="checkbox"/> 12- Home <input type="checkbox"/> 13- Assisted-Living Facility <input type="checkbox"/> 14- Group Home <input type="checkbox"/> 20- Urgent Care Facility <input type="checkbox"/> 22- On Campus- Outpatient Hospital <input type="checkbox"/> 33- Custodial Care Facility <input type="checkbox"/> 50- Federally Qualified Health Center <input type="checkbox"/> 53- Community Mental Health Center <input type="checkbox"/> 57- Non-residential Substance Abuse Treatment Facility <input type="checkbox"/> 71- Public Health Clinic <input type="checkbox"/> 72- Rural Health Clinic <input type="checkbox"/> 99- Other place of service not identified above
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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 <small>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.</small>	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		
Are all units exhausted? <input type="checkbox"/> Yes <input type="checkbox"/> No		If No, indicate amount used:		

SERVICE TYPE REQUESTED	LIST REV/CPT/HCPS CODE (S)	REQUESTED START DATE	REQUESTED NUMBER OF UNITS (NOT TO EXCEED A 3-MONTH PERIOD)

DIAGNOSIS – Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnoses	

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**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
<b>Inpatient admissions for behavioral health/substance abuse treatment?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Current Severity Rating

Functional Area	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of psychological functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of social functioning (family/school/work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment in support systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If substance abuse identified please provide details:

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

### 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	

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Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	
Discharge plan (date)	

  

Adherent to therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adherent to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**Please list rationale for additional therapy sessions:**

  

<p>Has the member made progress in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>If no, how has the treatment plan been modified accordingly?</p>
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<p>Does member have access to competent and available supports? <input type="checkbox"/> Yes <input type="checkbox"/> No    Please explain:</p>
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<p>Does the member have transportation to and/or from services? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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**\*\*\*Please submit a copy of the member's most recent Treatment Plan.**