WellCare Health Plans

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Behavioral Health Service Request Form

Detox and Substance Abuse Rehab

Medicare	
Call for Pre-Certification of Admissions	
Arkansas 855-538-0454 **Connecticut 855-538-0454** **Florida 855-538-0454** **Georgia 800-424-5412** **Illinois 800-504-2766** **Kentucky 855-620-1861** **Louisiana 855-538-0454**	**Mississippi 855-538-0454** **New Jersey 855-538-0454** **New York 800-288-5441** **North Carolina 855-538-0454** **South Carolina 855-538-0454** **Tennessee 855-538-0454** **Texas 855-538-0454**
Please Submit to the Dedicated Fax Line Below	
Arkansas 855-710-0159 **Connecticut 888-365-3233** **Florida 855-710-0167** **Georgia 855-710-0165** **Illinois 855-713-0592** **Kentucky 888-365-5615** **Louisiana 855-710-0159**	**Mississippi 855-710-0159** **New Jersey 855-703-8082** **New York 855-713-0588** **North Carolina 888-365-3233** **South Carolina 855-710-0159** **Tennessee 855-710-0159** **Texas 855-671-0258**

Level of Care:	☐ **Detox** ☐ **Substance Abuse Rehab**
Place of Service:	☐ **21- Inpatient Hospital** ☐ **51- Inpatient Psychiatric Hospital** ☐ **55- Residential Substance Abuse Treatment Facility** ☐ **56- Psychiatric Residential Treatment Center**

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**	

SERVICE TYPE REQUESTED	**REV/HCPCS Code(s)**			
Service Type:	**REV/HCPS Code :**			
Detox				
Rehab				
Service Request Start Date:	**Projected Length of Stay:**	**Original Admission Date (if different from Start Date Requested):**	**Transition of Care** ☐ **Yes** ☐ **No**	**Continuation of Care** ☐ **Yes** ☐ **No**

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DIAGNOSIS – Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	

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

Current CIWA Score: (if applicable)	**COW Score: (if applicable)**	**Current ASAM Dimension: Scores (if applicable)**	

INITIAL REVIEW REQUESTS
(See Continued Stay Review for Concurrent Reviews)

PRESENTING PROBLEM

Date Problem Began: **Duration:**

Presenting problem to be addressed by treatment plan:

Is member currently intoxicated? ☐ Yes ☐ No

Is member currently experiencing withdrawal symptoms? ☐ Yes ☐ No

Does the member have a history of delirium tremens or withdrawal seizures? ☐ Yes ☐ No

If yes, please describe:

Is there a trigger event identified? ☐ Yes ☐ No **Please describe:**

Substance	Method	Amount	Frequency	First Used	Last Used

Please check all withdrawal symptoms the member is experiencing:

Psychological/Physical				Changes in mood/personality (behavior)	
☐	Hand Tremors	☐	Impaired attention /memory	☐	Psychomotor agitation
☐	Sweating/Weakness	☐	Nausea/Vomiting	☐	Anxiety/Irritability
☐	Nystagmus	☐	Fluctuating vital signs	☐	Muscle/Bone/Joint Aches
☐	Insomnia	☐	Stomach Cramps	☐	Vital Signs:
Has member been medically cleared? ☐ Yes ☐ No					

CURRENT IMPAIRMENTS

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed
Check the current level of impairment for each category and provide a brief description:

Symptom	Scale	Description	Symptom	Scale	Description
Depressed Mood	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Substance Abuse/ Dependence**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	

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Nausea and Vomiting	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Agitation**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Tremor	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Generalized Anxiety**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Paroxysmal Sweats	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Visual Disturbances**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Unstable Vital Signs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Memory Impairment**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Delusions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Impaired Judgement**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Tactile Disturbances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Headache, fullness in Head**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Auditory Disturbances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Orientation and Clouding of Sensorium**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Socially Withdrawn/Isolating	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Interpersonal Conflict (hostile, intimidating)**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Poor Impulse Control	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Cravings/Preoccupation with Substances**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Drug Seeking Behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		**Work/School Problems**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	

Suicidal/Homicidal: ☐ Ideation ☐ Plan ☐ Means (Include previous attempts and dates)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Hallucinations: ☐ Auditory ☐ Visual ☐ Command (Include examples and dates)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

CURRENT/PREVIOUS TREATMENT

Indicate if any of the following are involved in the member's care and list Provider?

Psychiatrist: ☐ Yes ☐ No Provider: **PCP: ☐ Yes ☐ No Provider:**
Integrated Health Home: ☐ Yes ☐ No Provider:

If yes, when was the member last seen and what services are being rendered?

Is member currently receiving Outpatient services? ☐ Yes ☐ No

Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment? ☐ Yes ☐ No

Level of Care	Name or Provider / Facility	Dates	Successful
Inpatient / Detox:			☐ Yes ☐ No
Substance Abuse Rehab:			☐ Yes ☐ No
IOP/PHP:			☐ Yes ☐ No
Outpatient:			☐ Yes ☐ No

If treatment was not successful, please explain:

Please explain why the member cannot be managed safely in a less intensive level of care:

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Please list any other treatment received over the past two years:

Name of Provider/Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SUPPORT SYSTEMS & PERFORMANCE

Relationship/Supports (Identify issues/concerns? Is support available? Is support substance free?)

What are the environmental/community stressors and/or supports that contribute to the member's clinical status?

Describe the member/family engagement in treatment:

Is the member at risk of legal intervention or out-of-home placement? ☐ Yes ☐ No (describe)

Role performance school/work:

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe:			

Detail the expected discharge plan:

ATTACHMENTS

☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other:

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CONTINUED STAY REVIEW

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the past week that support the need for residential care. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.

Continued symptoms/behaviors:

Current CIWA Score: (if applicable)	**COW Score: (if applicable)**	**Current ASAM Dimension Scores (if applicable):**	

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed
Check the impairment level for each category and provide a brief description

Symptom	Scale	Description	Symptom	Scale	Description
Functioning	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Ability to follow instructions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Complete assignments	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Perform ADLs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Cravings/preoccupation with substances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Drug-seeking behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Withdrawal symptoms	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A				

Types of services offered	Total number of sessions attended	Total number of sessions missed	Is member cooperative with treatment?	Please provider an explanation of any 'no' responses
Individual Therapy			☐ Yes ☐ No	
Group Therapy			☐ Yes ☐ No	
Substance Abuse Counseling			☐ Yes ☐ No	
Family Therapy			☐ Yes ☐ No	
Psychiatric Interventions			☐ Yes ☐ No	

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe:			

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Detail changes to the discharge plan:

ATTACHMENTS				
☐ **Current Treatment Plan**	☐ **Incident Report(s)**	☐ **Psychological Report**	☐ **Psychiatric Report**	☐ **Other:**

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