



We're in this together:
Quality Health Care

Behavioral Health Service Request Form

PHP and IOP Services as Covered

Please Submit to the Dedicated Contract Fax Line Below

Medicaid
Nebraska 855-279-3683

Place of Service	<input type="checkbox"/> 11- Office <input type="checkbox"/> 22- Outpatient Hospital <input type="checkbox"/> 52- Psychiatric Facility-Partial Hospitalization <input type="checkbox"/> 53- Community Mental Health Center
Treatment Focus	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Dual Diagnosis

MEMBER INFORMATION			
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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			
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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			
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Name	Facility ID	NPI Number	
Street Address	City, State	Zip	
Phone Number	Fax Number	Office Contact	

Service type Requested	REV/HCPCS Code(s) and Number of Days/Units Requested
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PHP	REV/HCPC Code (s) :	Number of Days/Units :
IOP	REV/HCPC Code (s) :	Number of Days/Units :
Service Request Start Date:	Projected Length of Stay:	Transition of Care <input type="checkbox"/> Yes <input type="checkbox"/> No
		Continuation of Care <input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSIS – Code and Description	
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Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	

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

CLINICAL DETAILS	
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Current Symptoms and Behaviors:

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

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Is member motivated for treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Transportation available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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CURRENT RISKS

Check the risk level for each category and check all boxes that apply.

Risk to self (SI)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	With <input type="checkbox"/> ideation <input type="checkbox"/> intent <input type="checkbox"/> plan <input type="checkbox"/> means
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Risk to others (HI)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	With <input type="checkbox"/> ideation <input type="checkbox"/> intent <input type="checkbox"/> plan <input type="checkbox"/> means
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Current serious attempt or non-suicidal self injury	<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, describe below)	Check: <input type="checkbox"/> SI <input type="checkbox"/> HI
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If above checked yes, please describe :

Date of most recent attempt or non-suicidal self injury:

Prior serious attempt non-suicidal self injury	<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, describe below)	Check: <input type="checkbox"/> SI <input type="checkbox"/> HI
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If above checked yes, please describe :

Substance Abuse/Co-Morbidity

Does the member have a current Substance Use Disorder? Yes No

Is the member currently intoxicated? : Yes No If yes, please list substance (s) used :

Is the member currently experiencing withdrawal symptoms ? : Yes No If yes, please list substance (s) used :

Please check off all withdrawal symptoms the member is experiencing :

<input type="checkbox"/> Hand Tremors	<input type="checkbox"/> Impaired attention /memory	<input type="checkbox"/> Psychomotor agitation
<input type="checkbox"/> Sweating/Weakness	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Anxiety/Irritability
<input type="checkbox"/> Nystagmus	<input type="checkbox"/> Fluctuating vital signs	<input type="checkbox"/> Changes in Mood / Personality
<input type="checkbox"/> Insomnia	Vital Signs:	
Has member been medically cleared? <input type="checkbox"/> Yes <input type="checkbox"/> No		

ADDITIONAL DATA TO SUPPORT REQUEST

Is a psychiatrist involved in the member's care? Yes No

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 :			<input type="checkbox"/> Yes <input type="checkbox"/> No
Residential :			<input type="checkbox"/> Yes <input type="checkbox"/> No
IOP / PHP :			<input type="checkbox"/> Yes <input type="checkbox"/> No
Outpatient :			<input type="checkbox"/> Yes <input type="checkbox"/> No
Intensive Community Based Treatment :			<input type="checkbox"/> Yes <input type="checkbox"/> 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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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?

Role performance school/work issues/concerns:

Describe the member/family engagement in treatment:

Current living situation: homeless independent family foster home incarcerated other:

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

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication:	Dosage :	Frequency :	Compliant :
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Discharge Plan upon Admission :

ATTACHMENTS

Current Treatment Plan
 Biopsychosocial Assessment
 Court Order
 Psychiatric Report
 Other:

CONTINUED STAY REVIEWS

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the last week that support the need for partial hospitalization or intensive outpatient services. 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:



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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	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Ability to follow instructions	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Complete assignments	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Perform ADLs	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Cravings/preoccupation with substances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Drug-seeking behaviors	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Withdrawal symptoms	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A				

Types of services offered	Total number of sessions attended	Total number of sessions missed	Member Cooperative with Treatment?	Please provider an explanation of any "NO" responses
Individual Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Abuse Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric Interventions			<input type="checkbox"/> Yes <input type="checkbox"/> No	

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication:	Dosage :	Frequency :	Compliant :
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Detail any updates or changes to the discharge plan:

ATTACHMENTS

Current Treatment Plan Biopsychosocial Assessment Court Order Psychiatric Report Other: