



## Behavioral Health Service Request Form

Routine Outpatient Services as Covered

<b>&lt;Please Submit to the Dedicated Contract Fax Line Below&gt;</b>
<b>Medicaid</b>
<b>New York – 855-713-0591</b>

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
Traditional Outpatient Individual/Family/Group Therapy	
Other Comprehensive Community Services	
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	

<b>If request is for Mental Health please complete the following :</b>			
Current GAF/CAFAS		Highest GAF/CAFAS in Past Year	Current Total LOCUS/CALOCUS Score ( If applicable)

<b>If request is for Substance Abuse and member is 21 years of age or older, please complete the following :</b>			
LOCADTR Recommended Level of Care Identified * :		If requesting a different Level of Care than LOCADTR recommendation, please justify:	

\*Please submit a copy of the LOCADTR assessment conducted for this request.



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If request is for Substance Abuse and member is <b>under 21 years of age</b> please complete the following :			
Current ASAM Dimension Scores :			
Current GAF/CAFAS		Highest GAF/CAFAS in Past Year	
Current Total LOCUS/CALOCUS Score: (if applicable)		LOCADTR Recommended Level of Care Identified : *Please submit a copy of the LOCADTR assessment conducted for this request	
If requesting a different Level of Care than LOCADTR recommendation please justify			

### RATIONALE for REQUEST

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)	

### 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



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<b>Response to treatment (if poor response; how is the treatment plan being adjusted to address)</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
<b>Acceptance and engagement:</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
***If services are for ACT or Therapeutic Rehab Program- Please submit treatment plan/updates	