WellCare
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

Routine Outpatient Services as Covered

<Please Submit to the Dedicated Contract Fax Line Below>
Medicaid
New York – 855-713-0591

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	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** ☐Yes ☐ No	**Continuation of Care** ☐Yes ☐ 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)**

If request is for Substance Abuse and member is 21 years of age or older, please complete the following :			
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 under 21 years of age 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? ☐Yes ☐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	☐0 ☐1 ☐2 ☐3 ☐N/A
Functional Status	☐0 ☐1 ☐2 ☐3 ☐N/A
Co-Morbities	☐0 ☐1 ☐2 ☐3 ☐N/A
Environmental Stressors	☐0 ☐1 ☐2 ☐3 ☐N/A
Support in the environment	☐0 ☐1 ☐2 ☐3 ☐N/A

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