



# Behavioral Health Service Request Form

## ACT Services Request Form

Please Submit to the Dedicated Contract Fax Line Below

<b>Medicaid</b>					
New York 855-713-0591					
Place of Service <input type="checkbox"/> 11-Office <input type="checkbox"/> 12-Home <input type="checkbox"/> 22-Outpatient Hospital <input type="checkbox"/> 53-Community Mental Health Center					
<b>MEMBER INFORMATION</b>					
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	
<b>TREATING PROVIDER/PRACTITIONER INFORMATION</b>					
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	
<b>FACILITY/AGENCY INFORMATION</b>					
Name		Facility ID		NPI Number	
Street Address		City, State		Zip	
Phone Number		Fax Number		Office Contact	
<b>Service type Requested</b>			<b>List REV/CPT/HCPCS Code(s) and Number of Each Requested</b>		
ACT Services CPT Codes Requested					
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	
<b>DIAGNOSIS</b>					
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)	
<b>RATIONALE for REQUEST</b>					
Are services requested court ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes please submit a copy of the court order and all supporting documentation</i>					
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)					



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<b>Ongoing Problem: (describe)</b>	
<b>CURRENT IMPAIRMENTS</b>	
<b>Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed</b>	
<b>Select the impairment level for each category and give a brief description.</b>	
<b>Risk of Harm</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
<b>Functional Status</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
<b>Co-Morbidities</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
<b>Environmental Stressors</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
<b>Support in the environment</b>	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
<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