

Behavioral Health Service Request Form

Detox and Substance Abuse Rehab

Medicaid					
Call for Pre-Certification of Admissions: 1-800-288-5441					
New York Medicaid Fax: 1-855-713-0590					
<input type="checkbox"/>	Standard Request	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan seven (7) days prior to the date the requested services will be performed.			
<input type="checkbox"/>	Expedited Request	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.			
		_____ Physician Signature Validating Expedited Request	_____ Date Signed		
Level of Care:		<input type="checkbox"/> Detox <input type="checkbox"/> Substance Abuse Rehab			
Place of Service:		<input type="checkbox"/> 21- Inpatient Hospital <input type="checkbox"/> 51- Inpatient Psychiatric Hospital <input type="checkbox"/> 53 – Community Mental Health Center <input type="checkbox"/> 56 - Psychiatric Residential Treatment Center			
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	RE/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	Continuation of Care	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DIAGNOSIS – Code and Description					
Primary Diagnosis					
Secondary Diagnosis					
Medical Diagnosis					
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>					
Current CIWA Score: (if applicable)	COW Score: (if applicable)	Current ASAM Dimension Scores (if applicable):			

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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 :

Substances Used in the Past Year:	Frequency of Use :	Amount Used:	Last Use :

Please check off all withdrawal symptoms the member is experiencing :

Psychological/Physical				Changes in mood/personality (behavior)			
<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"/>	Muscle/Bone/Joint Aches		
<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Stomach Cramps	<input type="checkbox"/>	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	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Substance Abuse / Dependence	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Nausea and Vomiting	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Agitation	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Tremor	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Generalized Anxiety	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Paroxysmal Sweats	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Visual Disturbances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Unstable Vital Signs	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Memory Impairment	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Delusions	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Impaired Judgement	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Tactile Disturbances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Headache, fullness in Head	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Auditory Disturbances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Orientation and Clouding of Sensorium	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Socially Withdrawn/Isolating	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Interpersonal Conflict (hostile, intimidating)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Poor Impulse Control	<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		Work/School Problems	<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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Suicidal/Homicidal: <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means (Include previous attempts and dates)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Hallucinations: <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Command (Include examples and dates)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 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 :			<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Abuse Rehab :			<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

If treatment was not successful, please explain :

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

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

Name of Provider / Facility :	Dates :	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
		<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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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 the expected discharge plan:

ATTACHMENTS

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

CONTINUED STAY REVIEW

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the last 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):	
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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)

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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 changes to the discharge plan:

ATTACHMENTS

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