WellCare Health Plans

We're in this together: Quality Health Care

Behavioral Health Service Request Form

Inpatient, Sub-acute, and CSU Services

Medicaid		
Call for Pre-Certification of Admissions: 1-800-288-5441		
New York Medicaid Fax: 1-855-713-0590		
☐	**Retro Request**	**Please indicate if the services are completed and the member is no longer in Inpatient care. Please submit the member record for review.**
Level of Care:	☐ **Inpatient** ☐ **Sub-acute** ☐ **CSU**	
Place of Service:	☐ **21- Inpatient Hospital** ☐ **51- Inpatient Psychiatric Hospital** ☐ **53 – Community Mental Health Center**	
Please contact WellCare for authorization of Inpatient services at the time of admission or on the next business day following admission to a psychiatric Inpatient program. After the initial authorization determination, providers will be required to perform concurrent review for any additional Inpatient days authorized. This form should be used by providers to ensure our review process will be as quick and efficient as possible.		

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			
If services requested are for Subacute or Crisis Stabilization Unit please include REV/HCPS Code below.			
Service Type :	**REV/HCPCS Code :**		
Crisis Stabilization Unit			
Extended Care/ Sub-acute Unit			
Service Request Start Date:	**Projected Length of Stay:**	**Transition of Care** ☐ **Yes** ☐ **No**	**Continuation of Care** ☐ **Yes** ☐ **No**

DIAGNOSIS - Code and Description	
Primary Diagnosis	
Secondary Diagnosis	

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Medical Diagnosis	

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

REASON FOR ADMISSION

Presenting problem to be addressed by treatment plan:

Date problem began		Duration		Is member under the care of a psychiatrist	☐ Yes ☐ No
Is member currently inpatient	☐Yes ☐ No	If yes, what is the current length of stay?			

Is member currently receiving Outpatient services?
☐ Yes ☐ No

If yes :

Name of Provider / Facility :	Dates :	Compliant :
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

☐	I acknowledge that I am required to send a report of the member's admission to inpatient services to their PCP and I will update their PCP quarterly.

CURRENT RISK

Risk level scale: 0 = none; 1 = mild, ideation only; 2 = moderate, ideation with either a plan or history of attempts; 3 = severe, ideation AND plan, with either intent or means.

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

Risk to self (SI)	☐ 0 ☐ 1 ☐ 2 ☐ 3	With ☐ ideation ☐ intent ☐ plan ☐ means	
Risk to others (HI)	☐ 0 ☐ 1 ☐ 2 ☐ 3	With ☐ ideation ☐ intent ☐ plan ☐ means	
Current serious attempt or non-suicidal self-injury :	☐ Yes ☐ No (if yes, describe below)	Check: ☐ SI ☐ HI	Date of most recent attempt :

If checked yes above, please describe :

Prior serious attempt or non-suicidal self injury :	☐ Yes ☐ No (if yes, describe below)	Check: ☐ SI ☐ HI	Date of attempt:

If checked yes above, please describe :

CURRENT IMPAIRMENTS

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed

Check the impairment level for each category and any severe (3) impairments please provide brief description.

Mood Disturbance (depression, mania) :	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Anxiety :	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Psychosis :	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Thinking/cognition/memory	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

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Impulsive/recklessness/aggressive	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Activities of daily living	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Weight change associated with behavioral health diagnosis ☐ gain ☐ loss _____ lbs in last three months	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Medical/physical conditions:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Substance abuse/dependence	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Job/school performance	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Social/marital/family problems:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Legal :	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Stressors:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Orientation/alertness /awareness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

CURRENT / PREVIOUS TREATMENT

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?

History of hospitalization in the past year? ☐ Yes ☐ No

Name of Facility :	Dates :

Is a therapist currently involved in the members care? ☐ Yes ☐ No

Name of Current Provider / Facility	Dates :	Compliant :
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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

Name of Provider / Facility :	Dates :	Compliant :
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

CURRENT MEDICATIONS (Psychotropic and Medical)

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Medication:	Dosage :	Frequency :	Compliant :
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe :			

ADDITIONAL CLINICAL INFORMATION

Is the member at risk of legal intervention or out-of-home placement? Describe :

Describe the overall risk of harm (to self or others) :

What are the environmental/community stressors and/or supports that contribute to the member's clinical status?

Support System (describe) :

Describe the member/family engagement in treatment:

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

Detail the discharge plan: