Behavioral Health Service Request Form

Detox and Substance Abuse Rehab

<Please Submit to the Dedicated Contract Fax Line Below>	
Medicare	**Medicaid**
New York- 855-713-0590	**New York-** 855-713-0588
** Medicare: Please note- Rehab is only covered if services are provided in an inpatient hospital setting. (POS 21)	

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan fourteen (14) days prior to the date the requested services will be performed.
☐	**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

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	POS	List REV/CPT/HCPCS Code(s) and Number of Each Requested
Detox		
Rehab		

Start Date Requested:	**Expected Discharge Date:**	**Original Admission Date:**	**Transition of Care** ☐ **Yes** ☐ **No**

Signed ordered attached	☐ **Yes** ☐ **No**	All request require current, dated physician's orders as written or given if verbal	**Court ordered?**	☐ **Yes** ☐ **No**

DSM-IV DIAGNOSIS (AXIS I – V)			
Primary Diagnoses		**R/O**	
Secondary Diagnoses		**R/O**	
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 :			

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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.			
If request is for Substance Abuse and member is under 21 years of age please complete the following :			
Current ASAM Dimension Scores :			
ASAM Level of Care Identified :			

INITIAL REVIEW REQUESTS

Is member currently inpatient	☐ Yes ☐ No	Is member currently receiving Outpatient services	☐ Yes ☐ No
Has the member exhausted all lower levels of care? ☐ Yes ☐ No			
Previous Treatment History	**Dates of Treatment**	**Facility**	**Successful**
Inpatient/Detox			☐ Yes ☐ No
Substance Abuse Rehab			☐ Yes ☐ No
IOP/PHP			☐ Yes ☐ No
Outpatient			☐ Yes ☐ No
If placement was not successful, please explain:			
Drug(s) of choice:			
Is member currently intoxicated? ☐ Yes ☐ No			
Is member currently experiencing withdrawn symptoms? ☐ Yes ☐ No			

Please check off all withdraw symptoms the member is experiencing					
Physiologic				Changes in mood/personality/behavior	
☐	Hand Tremors	☐	Impaired attention/ Memory	☐	Psychomotor agitation
☐	Sweating/Weakness	☐	Nausea/ Vomiting	☐	Anxiety/Irritability
☐	Nystagmus	☐	Fluctuating Vital signs		
☐	Insomnia	Vital Signs:			

Has member been medically cleared?	☐ Yes ☐ No
Please attach your Initial plan of care (IPOC) included with all the required elements to include Individual Therapy (Quantity/Frequency/Length); treatment interventions (Frequency); Family Therapy as applicable.	
Date of physician's signature on completed IPOC:	

CURRENT SYMPTOMS

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed
**Circle the impairment level for each category

Symptom	Level	Symptom	Level
Depressed Mood	0 1 2 3 N/A	Substance Abuse/Dependence	0 1 2 3 N/A
Nausea and Vomiting	0 1 2 3 N/A	Agitation	0 1 2 3 N/A
Tremor	0 1 2 3 N/A	Generalized Anxiety	0 1 2 3 N/A
Paroxysmal Sweats	0 1 2 3 N/A	Visual Disturbances	0 1 2 3 N/A
Work/School Problems	0 1 2 3 N/A	Memory Impairment	0 1 2 3 N/A
Delusions	0 1 2 3 N/A	Impaired Judgment	0 1 2 3 N/A
Tactile Disturbances	0 1 2 3 N/A	Headache, fullness in Head	0 1 2 3 N/A
Auditory Disturbances	0 1 2 3 N/A	Orientation and Clouding of Sensorium	0 1 2 3 N/A

Suicidal/Homicidal ☐Ideation ☐ Plan ☐ Means (Include previous attempts and when)	0 1 2 3 N/A
Hallucinations: ☐ Auditory ☐ Visual ☐ Command	0 1 2 3 N/A
Relationships:	

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Role performance school/work:					
Current living situation?					
Date problem began:		**Duration:**		**Is member under the care of a psychiatrist**	☐ Yes ☐ No

CURRENT SYMPTOMS continued
Presenting problem to be addressed by treatment plan:
Detail the expected discharge plan:

CURRENT MEDICATIONS (Psychotropic and Medical)			
Medication	**Dosage**	**Frequency**	**Adherent?**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Any medication contraindications? If yes, describe.			