Behavioral Health Service Request Form

Inpatient, Sub-acute and CSU Services

<Please Submit to the Dedicated Contract Fax Line Below>	
Medicare	**Medicaid**
New York- 855-713-0588	**New York –** 855-713-0590

☐	**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 _____

CHOOSE ONE OF THE FOLLOWING							
Place of Service:	☐	**Inpatient**	☐	**Sub acute**	☐	**CSU**	

Please contact WellCare for prior 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.

NOTE: *WellCare uses McKesson InterQual Criteria as a tool to assist in determining medical necessity. Our medical necessity criteria and treatment guidelines can be found on our website at www.wellcare.com.*

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		
Acute Inpatient			
Crisis Stabilization Unit			
Extended Care/ Sub-acute Unit			
Service Request Start Date:	**Service Request End Date:**	**Transition of Care** ☐ **Yes** ☐ **No**	**Continuation of Care** ☐ **Yes** ☐ **No**

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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 :			
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 :			

RATIONALE for REQUEST

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.

Circle 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 gesture	**☐ Yes ☐ No (if yes, describe)**	**Circle: SI HI**
Date of most recent attempt or gesture:		
Prior serious attempt or gesture	**☐ Yes ☐ No (if yes, describe)**	**Circle: SI HI**

CURRENT IMPAIRMENTS

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

Circle the impairment level for each category.

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**
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**

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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: **Orientation/alertness /awareness**	**0 1 2 3 N/A**
Support System: (describe)	
Current living situation: (describe) **☐ Spouse ☐ Family ☐ Homeless**	

ADDITIONAL DATA TO SUPPORT REQUEST	
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 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?	
Describe the member/family engagement in treatment:	
Expected Discharge date:	
Detail the discharge plan:	

CURRENT MEDICATIONS (Psychotropic and Medical)			
Medication	**Dosage**	**Frequency**	**Adherent?**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Any medication contraindications? If yes, describe.			