Behavioral Health Service Request Form

Routine Outpatient Services as Covered

<Please Submit to the Dedicated Contract Fax Line Below>	
Medicare	**Medicaid**
New York – 855-713-0589	**New York –** 855-713-0591

☐	**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	List REV/CPT/HCPCS Code(s) and Number of Each Requested		
Traditional Outpatient Individual/Family/Group Therapy			
Other Comprehensive Community Services			
Service Request Start Date:	**Service Request End Date:**	**Transition of Care** ☐**Yes** ☐ **No**	**Continuation of Care** ☐**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 :			
LOCADTR Recommended Level of Care Identified * :		**If requesting a different Level of Care than LOCADTR recommendation, please justify:**	

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*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 :			
Current GAF/CAFAS		**Highest GAF/CAFAS in Past Year**	
Current Total LOCUS/CALOCUS Score: (if applicable)		**LOCADTR Recommended Level of Care Identified : *Please submit a copy of the LOCADTR assessment conducted for this request**	
If requesting a different Level of Care than LOCADTR recommendation please justify			

RATIONALE for REQUEST	
Is a psychiatrist involved in the member's care? ☐Yes ☐No	**When was member last seen?**
Presenting Problem: (describe)	
Ongoing Problem: (describe)	

CURRENT IMPAIRMENTS	
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed	
Circle the impairment level for each category and give a brief description.	
Risk of Harm	**0 1 2 3 N/A**
Functional Status	**0 1 2 3 N/A**
Co-Morbities	**0 1 2 3 N/A**
Environmental Stressors	**0 1 2 3 N/A**
Support in the environment	**0 1 2 3 N/A**
Response to treatment (if poor response; how is the treatment plan being adjusted to address)	**0 1 2 3 N/A**

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Acceptance and engagement:	**0 1 2 3 N/A**
***If services are for ACT or Therapeutic Rehab Program- Please submit treatment plan/updates	