WellCare
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

Routine Outpatient Services

Please Submit to the Dedicated Fax Line Below
Georgia Medicaid
1-888-871-0590

Place of Service	☐ 11- Office ☐ 12- Home ☐ 13- Assisted-Living Facility ☐ 14- Group Home ☐ 20- Urgent Care Facility ☐ 22- On Campus – Outpatient Hospital ☐ 33-Custodial Care Facility ☐ 50- Federally Qualified Health Center ☐ 53- Community Mental Health Center ☐ 57- Non-residential Substance Abuse Treatment Facility ☐ 71- Public Health Clinic ☐ 72- Rural Health Clinic ☐ 99- Other place of service not identified above

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

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, please 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**	

	I acknowledge my request for IFI services can only be billed for one sibling within a family.

Are all units exhausted? ☐ Yes ☐ No	**If No, indicate amount used:**

SERVICE TYPE REQUESTED	LIST REV/CPT/HCPS CODE (S)	Requested Start Date	REQUESTED NUMBER OF UNITS (NOT TO EXCEED A 3-MONTH PERIOD)

DIAGNOSIS – Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Problems	

Treatment Phase: Initiation (0-3 months) : ☐ Continuation (3-6 months) : ☐ Stabilization / Maintenance (over 6 months) : ☐

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

RISK FACTORS AND SYMPTOMS

Please describe the member's baseline behavior :

	Past 12 months	More than 12 months ago	Never
Inpatient admissions for behavioral health/substance abuse treatment?			

Current Severity Rating					
Functional Area	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others	☐	☐	☐	☐	
Impairment of psychological functioning	☐	☐	☐	☐	
Impairment of social functioning (family/school/work)	☐	☐	☐	☐	
Impairment of physical functioning	☐	☐	☐	☐	
Impairment in support systems	☐	☐	☐	☐	
Other (list)	☐	☐	☐	☐	

If substance abuse is identified, please provide details:

Name of substance used	Date of first use	Frequency of use	Date of last use

Treatment	
Functional Area	**Narrative explaining treatment interventions in each functional area of concern:**
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	

Discharge Goal	
Functional Area	**Narrative describing discharge goals for each functional area of concern:**
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	

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Discharge plan (date)			
Adherent to therapy?	☐ Yes ☐ No	Adherent to medications?	☐ Yes ☐ No

Please list rationale for additional therapy sessions :

Has the member made progress in treatment? ☐ **Yes** ☐ **No**
If yes, please describe:
If no, how has the treatment plan been modified accordingly?

Does the member have access to competent and available supports? ☐ **Yes** ☐ **No** **Please explain:**

Does the member have transportation to and/or from services? ☐ **Yes** ☐ **No**

*****Please submit a copy of the member's most recent Treatment Plan**