WellCare Health Plans

We're in this together: Quality Health Care

Behavioral Health Service Request Form

Residential Treatment Request Form

Medicaid
Call for Pre-Certification of Admissions: 1-800-424-5412
Georgia Medicaid Fax – 888-361-6574

☐	**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		
Residential			
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**	

DIAGNOSIS – Code and Description

Primary Diagnoses		**R/O**	
Secondary Diagnoses		**R/O**	
Medical Problems			
Current GAF/CAFAS		**Highest GAF/CAFAS in Past Year**	
Current Total LOCUS/CALOCUS Score: (if applicable)		**Current ASAM Dimension Scores: (if applicable)**	

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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
Inpatient	
IOP/PHP	
Outpatient	
Intensive Community-based treatment	

Alternative placements tried or explored in the past year?	☐ Yes ☐ No

Name of Placement(s)	Dates	Successful
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

If placement was not successful, please explain:

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, completed signed and dated as requested?

Date of physician's signature on completed IPOC:

MENTAL STATUS EXAM AND SYMPTOMS

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed
Check the impairment level for each category and provide a brief description

Depressed Mood	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	Substance Abuse/Dependence	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Self-Mutilation	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	Obsession/Compulsion	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Impaired Attention/Concentration	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	Generalized Anxiety	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Impulsivity	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	Cruelty to animals	☐ 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
Eating Disorders	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	Lack of Insight	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Fire Setting	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Suicidal/Homicidal ☐ Ideation ☐ Plan (Include previous attempts and when)			☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Hallucinations: ☐ Auditory ☐ Visual ☐ Command			☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Relationships:

Role performance school/work:

Current living situation?

Date problem began		Duration		Is member under the care of a psychiatrist	☐ Yes ☐ No

Presenting problem to be addressed by treatment plan:

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Detail the discharge plan:

CONTINUED STAY REVIEWS			
For continued stay, provide a narrative of the current symptoms/behaviors that support the need for residential care. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.			
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed **Check the impairment level for each category and provide a brief description**			
Functioning		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Ability to follow instructions		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Complete assignments		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Perform ADLs		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Types of services offered	**Total number of sessions attended**	**Member cooperative with treatment**	**Pleas provide an explanation of any sections checked "NO"**
Individual Counseling		☐ Yes ☐ No	
Group Counseling		☐ Yes ☐ No	
Psychiatric interventions		☐ Yes ☐ No	
Family Counseling		☐ Yes ☐ No	
Substance Abuse Counseling		☐ Yes ☐ No	
Sexual Reactive Treatment		☐ Yes ☐ No	
Sexual Offender Treatment		☐ Yes ☐ No	
Other services		☐ Yes ☐ No	
Has the member's behavior necessitated a significant change in treatment or supervision? ☐ **Yes** ☐ **No** **If yes, please specify the changes. (Use a separate sheet if necessary.)**			
Updates to discharge Plan		**Expected discharge date:**	

Method of Intervention	**Frequency**	**Has the use of these methods become more frequent? If so, please explain**
Use of Time-out		
Physical management/Restraint (does not include escorts or assists)		
Calls for outside assistance (law enforcement, non-agency staff, etc.)		
Other		
Does the member have any chronic illnesses that require staff supervision? If yes, indicate the illness, the severity and how staff time and resources are utilized.		

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Has the member experienced any acute illnesses, medical complications or medical hospitalizations during the last three months?

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.			

ATTACHMENTS				
☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other:

Georgia Families® Choices for a Healthy Life

PeachCare for Kids®

Planning for Healthy Babies®

WellCare proudly serves the *Georgia Medicaid* and *PeachCare for Kids®* members enrolled in the *Georgia Families®* program and women enrolled in the *Planning for Healthy Babies®* program.