Behavioral Health Service Request Form

Inpatient, Subacute and CSU Services

Medicare	
Call for Pre-certification of Admissions	
Arizona Liberty Plan Only: **1-877-778-1855**	
All Others: 1-855-538-0454	
Please Submit to the Dedicated Fax Line Below	
Arizona 1-855-713-0592; AZ Liberty 1-866-246-9832	**Kentucky 1-888-365-5615**
Florida 1-855-710-0167	**New Jersey 1-855-671-0257**
Hawaii 1-888-890-8219	**New York 1-855-713-0588**
Connecticut, Maine, North Carolina: 1-888-365-3233	**Texas 1-855-671-0258**
Arkansas, Louisiana, Mississippi, South Carolina, Tennessee: 1-855-710-0159	
Illinois, Indiana, Missouri, Michigan, New Hampshire, Ohio, Rhode Island, Vermont, Washington: 1-855-713-0592	

☐	**Retro Request**	**Please indicate if the services are completed and the member is no longer in Inpatient care. Please submit the member record for review.**
Level of Care:	☐ **Inpatient** ☐ **Subacute** ☐ **CSU**	
Place of Service:	☐ **21-Inpatient Hospital** ☐ **51-Inpatient Psychiatric Hospital** ☐ **53-Community Mental Health Center**	

Please contact WellCare for 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 must 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.

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**	

SERVICE TYPE REQUESTED	REV/HCPCS Code(s)
Service Type:	**REV/HCPS Code:**
Detox	
Rehab	

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Service Request Start Date:	Projected Length of Stay:	Original Admission Date (if different from Start Date Requested):	Transition of Care: ☐ Yes ☐ No	Continuation of Care: ☐ Yes ☐ No

DIAGNOSIS - Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnoses	

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

REASON FOR ADMISSION

Presenting problem to be addressed by treatment plan:

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

Is member currently inpatient	☐ Yes ☐ No	If yes, what is the current length of stay?	

Is member currently receiving Outpatient services?
☐ Yes ☐ No

If yes :

Name of Provider / Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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

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.

Check 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 non-suicidal self-injury:	☐ Yes ☐ No (If yes, describe below)	Check: ☐ SI ☐ HI	Date of most recent attempt:	
If checked yes above, please describe:				
Prior serious attempt or non-suicidal self-injury:	☐ Yes ☐ No (If yes, describe below)	Check: ☐ SI ☐ HI	Date of attempt:	

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If checked yes above, please describe:

WellCare
Beyond Healthcare. A Better You.

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CURRENT IMPAIRMENTS	
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed Check the impairment level for each category and please provide brief description of any severe (3) impairments.	
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 past 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
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	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Orientation/alertness/awareness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

CURRENT/PREVIOUS TREATMENT

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 a therapist currently involved in the members care? ☐ Yes ☐ No

Name of Current Provider/Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Please list any other treatment received over the past two years:

Name of Provider/Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe:			

ADDITIONAL CLINICAL INFORMATION

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?
Support System (describe):
Describe the member/family engagement in treatment:
Current living situation: ☐ homeless ☐ independent ☐ family ☐ foster home ☐ incarcerated ☐ other:
Detail the discharge plan: