WellCare | Healthy Connections

Behavioral Health Service Request Form:

Inpatient and Partial Hospitalization Services as Covered

<Please Submit to the Dedicated Contract Fax Line Below>

Medicaid
South Carolina- 888-339-8293

CHOOSE ONE OF THE FOLLOWING:					
☐	Inpatient Hospital (21)	☐	Inpatient Psychiatric Facility (51)	☐	Psychiatric Facility – Partial Hospitalization (52)

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	☐ Female ☐ Male
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.		Medical Record Number	

ORDERING PHYSICIAN/PRACTITIONER INFORMATION					
Last Name		First Name		NPI Number	
WellCare ID Number		Type	☐ PCP ☐ Specialist	Specialty	
Participating	☐ Yes ☐ No	Phone Number		Fax Number	
Street Address		City, State		Zip	
Name of Requestor		Office Contact (If Different)			

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 INFORMATION					
Name		Facility ID		NPI Number	
Street Address		City, State		Zip	
Phone Number		Fax Number		Office Contact	

REQUESTED SERVICES							
Start Date		End Date		Original Date of Admission		Requested length of stay	days
Primary ICD-9 Code(s)		Description/Condition					
Additional ICD-9 Code(s)		Description/Condition					

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CPT/HCPCS Code(s)		**Description/Procedure**	
Clinical Summary/Presenting problem or reason for admission			

CURRENT SYMPTOMS: Check all that apply

☐ Suicidal/Homicidal Ideation	☐ Impaired Attention/ Concentration	☐ Sleep Disturbance	☐ Motoric Disturbance
☐ Social Isolation		☐ Eating Problems	☐ Memory Impairment
☐ Depressed Mood	☐ Impulsivity	☐ Coping with pain	☐ Disorientation
☐ Hopelessness/Helplessness	☐ Oppositional	☐ Substance Abuse/Dependence	☐ Impaired Judgment
☐ Irritability	☐ Tantrums	☐ Rage/Anger	☐ Lack of Insight
☐ Anhedonia	☐ Work/School Problems	☐ Phobia	☐ Distorted Thinking
☐ Mood Swings	☐ Hallucinations	☐ Obsession/Compulsion	☐ Distrustful/Suspicious
☐ Verbal/Physical/Sexual Abuse	☐ Delusions	☐ Panic Attacks	☐ Hyperactivity
☐ Victim	☐ Thought Disturbance	☐ Generalized Anxiety	☐ Fire setting
☐ Perpetrator	☐ Pressured Speech	☐ Cruelty to animals	☐ Bed wetting
☐ Self-Mutilation	☐ Grandiosity		

RATIONALE

What is the purpose of treatment for this member? Include relevant history.

Identify the treatment goals.

Describe how the treatment plan will affected the treatment outcomes. (Please attach a copy of the current treatment plan)

Are there other reasons treatment is necessary?

Is this treatment court or research related or for admission to a program or school?

Has there been any prior outpatient treatment? ☐ Yes ☐ No (If yes, please specify the dates).

Treatment failure? ☐ Yes ☐ No (If yes, please specify the previous treatment).

Current Medications (Please indicate if the member is compliant)

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DSM-IV DIAGNOSIS (AXIS I – V)			
Indicate any change in diagnostic presentation.			
Axis I		R/O	
Axis II		R/O	
Axis III			
Axis IV (Psychological Stressors)			
Axis V – Current GAF		Highest GAF in Past Year	

CURRENT RISKS		
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; na = not assessed. 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	☐ Yes ☐ No	Circle: SI HI
Prior serious attempt	☐ Yes ☐ No	Circle: SI HI GIVE SPECIFIC EXAMPLES
Prior serious gestures	☐ Yes ☐ No	Circle: SI HI
Date of most recent attempt or gesture:		

CURRENT IMPAIRMENTS	
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; na = not assessed Circle the impairment level for each category.	
Mood Disturbance (depression, mania)	0 1 2 3 na
Anxiety	0 1 2 3 na
Psychosis	0 1 2 3 na
Thinking/cognition/memory	0 1 2 3 na
Impulsive/recklessness/aggressive	0 1 2 3 na
Activities of daily living	0 1 2 3 na
Weight change associated with Behavioral Health diagnosis ☐ gain ☐ loss _____ lbs in last three months	0 1 2 3 na
Medical/physical conditions	0 1 2 3 na
Substance abuse/dependence	0 1 2 3 na
Job/school performance	0 1 2 3 na
Social/marital/family problems	0 1 2 3 na
Legal	0 1 2 3 na
Stressors Orientation/alertness /awareness Supports Job/school performance Social/marital/family problems	0 1 2 3 na

0

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Medication	Dosage	Frequency	Adherent?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

VITALS

BP		Temp		Pulse		Resp.		Bal		UDS	☐ Yes ☐ No

If a urine drug screen (UDS) was conducted, please detail the outcome.

PREVIOUS TREATMENT

Is the member currently in psychiatric or substance abuse treatment with any other treatment provider (CMHC or private physician) at the time of this admission? ☐ **Yes** ☐ **No** Include documentation of what outpatient services are currently being provided and by whom. Include what other treatment may have been tried but failed and by whom. Request medical records from previous treatment providers

Provider/Organization Name	Address	Phone Number	Contact Person

Attachments for continued stay consideration:

1. History and Physical (H&P) with psychiatric evaluation
2. Psychosocial Assessment
3. A detailed current treatment plan with meds, types of therapies, hours per day in treatment. Description of goals and how progress will be assessed.
4. Lab work including any urine drug screen results

DISCHARGE INFORMATION

Primary Care Physician	

PLEASE FAX A COPY OF THE DISCHARGE SUMMARY TO THE MEMBER'S PRIMARY CARE PHYSICIAN AND BEHAVIORAL HEALTH PROVIDER UPON DISCHARGE

Discharge Plan		Expected Discharge Date	

Planned Discharge level of care: (Check all that apply.)

☐ Outpatient with current treatment provider	☐ Outpatient new referral
☐ Partial hospital/CMHC day treatment	☐ Intensive Outpatient/CMHC Rehab services
☐ Residential treatment (under the age of 21)	☐ Referral to Substance Abuse Treatment provider

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☐ Targeted Case Management with CMHC provider		☐ Other	
Actual Discharge Date		**Actual Discharge Level of Care**	
Actual Discharge Receiving Provider or Facility			
Prior Authorization for next level of care (if required) obtained? ☐ **Yes** ☐ **No** ☐ **No Authorization Required**			
All follow-up appointments must be within seven (7) days, but no later than fourteen (14) days of discharge from Inpatient level of care. It is the Inpatient providers' responsibility (as part of their discharge planning process) to assure that the follow-up appointment has been made prior to discharge.			

FOLLOW-UP APPOINTMENT INFORMATION					
Provider Name		**Appointment Date**		**Appointment Time**	
Address		**City, State**		**Zip**	
Comments					

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