WellCare | Healthy Connections

Behavioral Health Service Request Form

Intensive Outpatient and Routine Outpatient Services as Covered
<Please Submit to the Dedicated Contract Fax Line Below:>

Medicaid
South Carolina- 888-343-5364

CHOOSE THE APPROPRIATE REQUEST TYPE		
☐	**Standard Request**	FOR OUT OF NETWORK PROVIDERS ONLY PRIOR AUTHORIZATION IS REQUIRED FOR ALL SERVICES. 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 _____

REQUEST TYPE									
Initial	☐	**Recertification**	☐	**Change**	☐	**Authorization #**		**Request Date**	

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.		**Languages spoken**	

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

Authorizations will be given for medically necessary services only; it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergency care does not require prior authorization. An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result (without immediate medical attention) in serious jeopardy to the health of an individual. *Urgent care is defined as medically necessary treatment for an injury, illness or type of condition (usually not life threatening) which should be treated within 24 hours. (Effective October 1, 2011)

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Start Date		**End Date**		**Transition of Care**	☐ Yes ☐ No	**Continuation of Care**	☐ Yes ☐ No
Primary CPT/ICD-9 or HCPS Code(s) and Hours/Units of Each Requested		**Description/Condition**					

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**	

PRESENTING PROBLEM and PATIENT SYMPTOMOLOGY

Include the date the problem(s) began along with the duration		**Psychiatrist involved in care?**	☐ Yes ☐ No

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?

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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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