WellCare | Healthy Connections

Behavioral Health Service Request Form

ACT Services Request Form

Please Submit to the Dedicated Contract Fax Line Below

Medicaid
South Carolina 888-343-5364

Place of Service	☐ 11- Office ☐ 12- Home ☐ 22- Outpatient Hospital ☐ 53- Community Mental Health Center				
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
ACT Services CPT Codes Requested	

Service Request Start Date:	**Service Request End Date:**	**Transition of Care** ☐Yes ☐ No	**Continuation of Care** ☐Yes ☐ No

DIAGNOSIS	
Primary Diagnoses	
Secondary Diagnoses	
Medical Problems	

If request is for Mental Health please complete the following :

Current GAF/CAFAS		**Highest GAF/CAFAS in Past Year**	**Current Total LOCUS/CALOCUS Score (If applicable)**

RATIONALE for REQUEST	
Are services requested court ordered? ☐ Yes ☐ No *If yes please submit a copy of the court order and all supporting documentation*	
Is a psychiatrist involved in the member's care? ☐Yes ☐No	**When was member last seen?**
Presenting Problem: (describe)	

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Ongoing Problem: (describe)	
CURRENT IMPAIRMENTS	
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed	
Circle the impairment level for each category and give a brief description.	
Risk of Harm	☐0 ☐1 ☐2 ☐3 ☐N/A
Functional Status	☐0 ☐1 ☐2 ☐3 ☐N/A
Co-Morbities	☐0 ☐1 ☐2 ☐3 ☐N/A
Environmental Stressors	☐0 ☐1 ☐2 ☐3 ☐N/A
Support in the environment	☐0 ☐1 ☐2 ☐3 ☐N/A
Response to treatment (if poor response; how is the treatment plan being adjusted to address)	☐0 ☐1 ☐2 ☐3 ☐N/A
Acceptance and engagement:	☐0 ☐1 ☐2 ☐3 ☐N/A