

Behavioral Health Service Request Form

Routine Outpatient Services

Medicaid

South Carolina 888-343-5364

Place of Service	<input type="checkbox"/> 11- Office <input type="checkbox"/> 12- Home <input type="checkbox"/> 13- Assisted-Living Facility <input type="checkbox"/> 14- Group Home <input type="checkbox"/> 20- Urgent Care Facility <input type="checkbox"/> 22- On Campus – Outpatient Hospital <input type="checkbox"/> 33- Custodial Care Facility <input type="checkbox"/> 50- Federally Qualified Health Center <input type="checkbox"/> 53- Community Mental Health Center <input type="checkbox"/> 57- Non-residential Substance Abuse Treatment Facility <input type="checkbox"/> 71- Public Health Clinic <input type="checkbox"/> 72- Rural Health Clinic <input type="checkbox"/> 99- Other place of service not identified above
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MEMBER INFORMATION

Last Name	First Name, Middle Initial	Date of Birth
Phone Number	WellCare ID Number	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Third-Party Insurance <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> 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/HCPS CODE (S)	REQUESTED NUMBER OF UNITS (NOT TO EXCEED A 3-MONTH PERIOD)

DIAGNOSIS – Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Problems	

Treatment Phase: Initiation (0-3 months): Continuation (3-6 months): Stabilization/ Maintenance (over 6 months):

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

RISK FACTORS AND SYMPTOMS

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Please describe the members baseline behavior :

	Past 12 months	More than 12 months ago	Never
Inpatient admissions for behavioral health/substance abuse treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Current Severity Rating					
Functional Area	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of psychological functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of social functioning (family/school/work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment of physical functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Impairment in support systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If substance abuse identified please provide details:

Name of substance used	Date of first use	Frequency of use	Date of last use

Treatment	
Functional Area	Narrative explaining treatment interventions in each functional area of concern:
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	

Discharge Goal	
Functional Area	Narrative describing discharge goals for each functional area of concern:
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	

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Impairment in support systems							
Other (list)							
Discharge plan (date)							
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Adherent to therapy?</td> <td style="width: 25%;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 25%;">Adherent to medications?</td> <td style="width: 25%;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>				Adherent to therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adherent to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Adherent to therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adherent to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Please list rationale for additional therapy sessions :							
Has the member made progress in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: If no, how has the treatment plan been modified accordingly?							
Does member have access to competent and available supports? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:							
Does the member have transportation to and/or from services? <input type="checkbox"/> Yes <input type="checkbox"/> No							
***Please submit a copy of the member's most recent Treatment Plan							