

# Behavioral Health Service Request Form

## PHP and IOP Services as Covered

Please Submit to the Dedicated Contract Fax Line Below

<b>Medicaid</b>
<b>South Carolina - 1-888-339-8293</b>

<b>Place of Service</b>	<input type="checkbox"/> 11- Office <input type="checkbox"/> 22- Outpatient Hospital <input type="checkbox"/> 52- Psychiatric Facility-Partial Hospitalization <input type="checkbox"/> 53- Community Mental Health Center
<b>Treatment Focus</b>	<input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> Dual Diagnosis

<b>MEMBER INFORMATION</b>
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<b>Last Name</b>	<b>First Name, Middle Initial</b>	<b>Date of Birth</b>	
<b>Phone Number</b>	<b>WellCare ID Number</b>	<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Third Party Insurance</b>	<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.		<b>Languages Spoken</b>

<b>TREATING PROVIDER/PRACTITIONER INFORMATION</b>
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<b>Last Name</b>	<b>First Name</b>	<b>NPI Number</b>	
<b>WellCare ID Number</b>	<b>Participating</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Discipline/ Specialty</b>
<b>Street Address</b>	<b>City, State</b>	<b>Zip</b>	
<b>Phone Number</b>	<b>Fax Number</b>	<b>Office Contact</b>	

<b>FACILITY/AGENCY INFORMATION</b>
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<b>Name</b>	<b>Facility ID</b>	<b>NPI Number</b>	
<b>Street Address</b>	<b>City, State</b>	<b>Zip</b>	
<b>Phone Number</b>	<b>Fax Number</b>	<b>Office Contact</b>	

<b>Service type Requested</b>	<b>REV/HCPCS Code(s) and Number of Days/Units Requested</b>
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<b>PHP</b>	<b>REV/HCPC Code (s) :</b>	<b>Number of Days/Units :</b>
<b>IOP</b>	<b>REV/HCPC Code (s) :</b>	<b>Number of Days/Units :</b>
<b>Service Request Start Date:</b>	<b>Projected Length of Stay:</b>	<b>Transition of Care</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>Continuation of Care</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>DIAGNOSIS – Code and Description</b>
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<b>Primary Diagnosis</b>	
<b>Secondary Diagnosis</b>	
<b>Medical Diagnosis</b>	

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

<b>CLINICAL DETAILS</b>
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**Current Symptoms and Behaviors:**

Is there a trigger event identified?  Yes    No  
 Please describe :

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Is member motivated for treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is Transportation available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**CURRENT RISKS**

**Check the risk level for each category and check all boxes that apply.**

Risk to self (SI)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	With <input type="checkbox"/> ideation <input type="checkbox"/> intent <input type="checkbox"/> plan <input type="checkbox"/> means
Risk to others (HI)	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	With <input type="checkbox"/> ideation <input type="checkbox"/> intent <input type="checkbox"/> plan <input type="checkbox"/> means
Current serious attempt or non-suicidal self injury	<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, describe below)	Check: <input type="checkbox"/> SI <input type="checkbox"/> HI
If above checked yes, please describe :		
Date of most recent attempt or non-suicidal self injury:		
Prior serious attempt non-suicidal self injury	<input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, describe below)	Check: <input type="checkbox"/> SI <input type="checkbox"/> HI
If above checked yes, please describe :		

**Substance Abuse/Co-Morbidity**

Does the member have a current Substance Use Disorder?  Yes  No

Is the member currently intoxicated? : <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list substance (s) used :	
Is the member currently experiencing withdrawal symptoms ? : <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list substance (s) used :	
<b>Please check off all withdrawal symptoms the member is experiencing :</b>		
<input type="checkbox"/> Hand Tremors	<input type="checkbox"/> Impaired attention /memory	<input type="checkbox"/> Psychomotor agitation
<input type="checkbox"/> Sweating/Weakness	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Anxiety/Irritability
<input type="checkbox"/> Nystagmus	<input type="checkbox"/> Fluctuating vital signs	<input type="checkbox"/> Changes in Mood / Personality
<input type="checkbox"/> Insomnia	Vital Signs:	
Has member been medically cleared? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**ADDITIONAL DATA TO SUPPORT REQUEST**

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?

Is member currently receiving Outpatient services?  Yes  No

Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment?  Yes  No

	Level of Care :	Name or Provider / Facility :	Dates:	Successful :
	Inpatient :			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Residential :			<input type="checkbox"/> Yes <input type="checkbox"/> No
	IOP / PHP :			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Outpatient :			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Intensive Community Based Treatment :			<input type="checkbox"/> Yes <input type="checkbox"/> No

If treatment was not successful, please explain :

Please explain why the member cannot be managed safely in a less intensive level of care :

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SUPPORT SYSTEMS & PERFORMANCE
Relationship/Supports (identify issues/concerns: Is support available / Is support substance free?)
What are the environmental/community stressors and/or supports that contribute to the member's clinical status?
Role performance school/work issues/concerns:
Describe the member/family engagement in treatment:
Current living situation: <input type="checkbox"/> homeless <input type="checkbox"/> independent <input type="checkbox"/> family <input type="checkbox"/> foster home <input type="checkbox"/> incarcerated <input type="checkbox"/> other:
Is the member at risk of legal intervention or out-of-home placement? <input type="checkbox"/> Yes <input type="checkbox"/> No (describe)

CURRENT MEDICATIONS (Psychotropic and Medical)			
<b>Medication:</b>	<b>Dosage :</b>	<b>Frequency :</b>	<b>Compliant :</b>
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any medication contraindications? If yes, please describe :			
Discharge Plan upon Admission :			

ATTACHMENTS				
<input type="checkbox"/> Current Treatment Plan	<input type="checkbox"/> Biopsychosocial Assessment	<input type="checkbox"/> Court Order	<input type="checkbox"/> Psychiatric Report	<input type="checkbox"/> Other:

CONTINUED STAY REVIEWS
For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the last week that support the need for partial hospitalization or intensive outpatient services. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.
Continued symptoms/behaviors:

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Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed  
 Check the impairment level for each category and provide a brief description

Symptom:	Scale:	Description:	Symptom:	Scale:	Description:
Functioning	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Ability to follow instructions	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Complete assignments	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Perform ADLs	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Cravings/preoccupation with substances	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Drug-seeking behaviors	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Withdrawal symptoms	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A				

Types of services offered	Total number of sessions attended	Total number of sessions missed	Member Cooperative with Treatment?	Please provide an explanation of any "NO" responses
Individual Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Abuse Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric Interventions			<input type="checkbox"/> Yes <input type="checkbox"/> No	

### CURRENT MEDICATIONS (Psychotropic and Medical)

Medication:	Dosage :	Frequency :	Compliant :
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any medication contraindications? If yes, please describe :			

Detail any updates or changes to the discharge plan:

### ATTACHMENTS

Current Treatment Plan     Biopsychosocial Assessment     Court Order     Psychiatric Report     Other: