# Behavioral Health Service Request Form

## Routine Outpatient Services

| Please Submit to the Dedicated Fax Line Below |
|---|
| **Georgia Medicare** |
| Medicare Only Members: 1-877-892-8213 |
| Dual Eligible Members (Members with Medicare & Medicaid Policies): 1-855-292-0233 |
| Discharge Planning: 1-855-776-9464 |

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

**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** | |

| | |
|---|---|
| **Are all units exhausted?** ☐ Yes ☐ No | **If No, indicate amount used:** |

| SERVICE TYPE REQUESTED | LIST REV/CPT/HCPS CODE (S) | REQUESTED START DATE | REQUESTED NUMBER OF UNITS (NOT TO EXCEED A 3-MONTH PERIOD) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**DIAGNOSIS – Code and Description**

| | |
|---|---|
| **Primary Diagnosis** | |
| **Secondary Diagnosis** | |
| **Medical Diagnoses** | |

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**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

**Please describe the member's baseline behavior :**

| | Past 12 months | More than 12 months ago | Never |
|---|---|---|---|
| **Inpatient admissions for behavioral health/substance abuse treatment?** | ☐ | ☐ | ☐ |

| Current Severity Rating | | | | | |
|---|---|---|---|---|---|
| **Functional Area** | None | Mild | Moderate | Severe | Explain Rating |
| Risk of harm to self or others | ☐ | ☐ | ☐ | ☐ | |
| Impairment of psychological functioning | ☐ | ☐ | ☐ | ☐ | |
| Impairment of social functioning (family/school/work) | ☐ | ☐ | ☐ | ☐ | |
| Impairment of physical functioning | ☐ | ☐ | ☐ | ☐ | |
| Impairment in support systems | ☐ | ☐ | ☐ | ☐ | |
| Other (list) | ☐ | ☐ | ☐ | ☐ | |

**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 | |

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| | |
|---|---|
| Impairment in social functioning (family/school/work) | |
| Impairment of physical functioning | |
| Impairment in support systems | |
| Other (list) | |
| Discharge plan (date) | |

| | | | |
|---|---|---|---|
| Adherent to therapy? | ☐ Yes ☐ No | Adherent to medications? | ☐ Yes ☐ No |

**Please list rationale for additional therapy sessions:**

| |
|---|
| |
| |
| |

**Has the member made progress in treatment?** ☐ **Yes** ☐ **No**
**If yes, please describe:**
**If no, how has the treatment plan been modified accordingly?**

**Does member have access to competent and available supports?** ☐ **Yes** ☐ **No** **Please explain:**

**Does the member have transportation to and/or from services?** ☐ **Yes** ☐ **No**

*****Please submit a copy of the member's most recent Treatment Plan.**