

Behavioral Health Service Request Form

Residential Treatment Request Form

Please Submit to the Dedicated Fax Line Below

Medicaid
Call for Pre-Certification of Admissions 800-322-6027
Missouri Medicaid Fax 855-599-3811

Place of Service	<input type="checkbox"/> 55- Residential Substance Abuse Treatment Facility <input type="checkbox"/> 56- Psychiatric Residential Treatment Center
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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		Languages Spoken	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.

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/ HCPCS Code(s)
Residential: <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Abuse	
Effective Date Requested:	Projected Length of Stay :
	Original Admission Date(if different from Effective Date) :
	Transition of Care
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Continuity of Care
	<input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSIS – Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	

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

INITIAL REVIEW REQUESTS (For Continued Stay Review – go to next page)
Presenting problem to be addressed by treatment plan:

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Date problem began		Duration		Is member under the care of a psychiatrist	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is member currently inpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what facility is member admitted and what is the current length of stay?			
Does the member have any chronic illnesses that require staff supervision? If yes, indicate the illness, the severity and how staff time and resources are utilized.					
Has the member experienced any acute illnesses, medical complications or medical hospitalizations during the last three months?					
Does the member have a current Substance Use Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please list substance(s) used :					
Substances Used in the Past Year:	Frequency of Use :	Amount Used:	Last Use :		
Has the member exhausted all lower levels of care?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please explain why the member cannot be managed safely in a less intensive level of care :					
CURRENT/PREVIOUS TREATMENT					
Is member currently receiving Outpatient services? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes :					
Name of Provider / Facility :	Dates :	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			
Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Level of Care :	Name or Provider / Facility :	Dates:	Compliant :		
Inpatient :			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Residential :			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Partial Hospitalization :			<input type="checkbox"/> Yes <input type="checkbox"/> No		
IOP/PHP			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Intensive Community Based Treatment :			<input type="checkbox"/> Yes <input type="checkbox"/> No		

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If treatment / placement was not successful, please explain:

Has the member exhausted all lower levels of care? Yes No

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

MENTAL STATUS EXAM AND SYMPTOMS

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

Symptom:	Scale:	Description:	Symptom:	Scale:	Description:
Depressed Mood	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Substance Abuse / Dependence	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Self-Mutilation	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Substance Use Withdrawal	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Impaired Attention/Concentration	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Cravings	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Impulsivity/Dangerous Behaviors	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Cruelty to animals	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Work/School/ADL Problems	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Memory Impairment	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Delusions	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Impaired Judgement	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Eating Disorders	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Lack of Insight	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Fire Setting	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Generalized Anxiety	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Obsession/Compulsion	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		Sexually Inappropriate/Aggressive	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	
Illegal Activities	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A				

Suicidal/Homicidal Ideation Plan 0 1 2 3
 N/A

Provide details including previous attempts and dates :

Hallucinations: Auditory Visual Command 0 1 2 3
 N/A

Provide details including previous examples and dates :

SUPPORT SYSTEMS & PERFORMANCE

Relationships/Supports (issues / concerns; Is support available / Is support substance free?)

Please provide details:

Role performance school/work issues/concerns:

Please provide details:

Current living situation? homeless independent family foster home incarcerated other:

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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 :

Discharge Plan upon Admission:

ATTACHMENTS

Current Treatment Plan
 Incident Report(s)
 Psychological Report
 Psychiatric Report
 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 residential care. 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:

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	

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 Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Group Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric interventions			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance Abuse Counseling			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexual Reactive Treatment			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sexual Offender Treatment			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other services			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Has the member's behavior necessitated a significant change in treatment, medication, or supervision? Yes No

If yes, please specify the changes (use a separate sheet if necessary)

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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 :			
Method of Intervention		Frequency	Has the use of these methods become more frequent? If so, please explain
Use of Time-out			
Physical management/Restraint (does not include escorts or assists)			
Calls for outside assistance (law enforcement, non-agency staff, etc.)			
Other			
Updates to Discharge Plan:		Expected discharge date:	
ATTACHMENTS			
<input type="checkbox"/> Current Treatment Plan	<input type="checkbox"/> Incident Report(s)	<input type="checkbox"/> Psychological Report	<input type="checkbox"/> Psychiatric Report
<input type="checkbox"/> Other:			