

# Behavioral Health Service Request Form

## Routine Outpatient Services

<b>Missouri – 866-946-2052</b>
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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/HCPCS 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 Problems	

<b>Treatment Phase:</b> Initiation (0-3 months) : <input type="checkbox"/> Continuation (3-6 months) : <input type="checkbox"/> Stabilization / Maintenance (over 6 months) : <input type="checkbox"/>
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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
<b>Inpatient admissions for behavioral health/substance abuse treatment?</b>	<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	

## Behavioral Health Service Request Form

### Routine Outpatient Services

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

Adherent to therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adherent to medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**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 the 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**