

Behavioral Health Service Request Form

Inpatient, Sub-acute, and CSU Services
Please submit to the Dedicated Contract Fax Line Below

Medicaid

Call for Pre-Certification of Admissions 855-599-3811

Nebraska Medicaid Fax 877-849-5071

<input type="checkbox"/>	Retro Request	Please indicate if the services are completed and the member is no longer in active Inpatient care. Please submit the member record for review.
Level of Care:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Sub-acute <input type="checkbox"/> CSU	
Place of Service:	<input type="checkbox"/> 21- Inpatient Hospital <input type="checkbox"/> 51- Inpatient Psychiatric Hospital <input type="checkbox"/> 53 – Community Mental Health Center	
Please contact WellCare for prior authorization of Inpatient services at the time of admission or on the next business day following admission to a psychiatric Inpatient program. After the initial authorization determination, providers will be required to perform concurrent review for any additional Inpatient days authorized. This form should be used by providers to ensure our review process will be as quick and efficient as possible.		

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

If services requested are for Subacute or Crisis Stabilization Unit please include REV/HCPs Code			
Crisis Stabilization Unit			
Extended Care/ Sub-acute Unit			
Service Request Start Date:	Projected Length of Stay:	Transition of Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Continuation of Care <input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSIS – Code and Description

Primary Diagnosis	R/O
Secondary Diagnosis	R/O
Medical Diagnosis	

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Are services requested court ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes please submit a copy of the court order and all supporting documentation</i>			
RATIONALE for REQUEST			
CURRENT RISK			
Risk level scale: 0 = none; 1 = mild, ideation only; 2 = moderate, ideation with either a plan or history of attempts; 3 = severe, ideation AND plan, with either intent or means.			
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	Date of most recent attempt :
If above checked yes, please describe :			
Prior 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	Date of attempt:
If checked yes above, please describe :			
CURRENT IMPAIRMENTS			
Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed			
Check the impairment level for each category and any severe (3) impairment please provide brief description.			
Mood Disturbance (depression, mania) :	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Anxiety :	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Psychosis :	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Thinking/cognition/memory	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Impulsive/recklessness/aggressive	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Activities of daily living	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Weight change associated with Behavioral Health diagnosis <input type="checkbox"/> gain <input type="checkbox"/> loss _____ lbs in last three months	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Medical/physical conditions:	<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		
Job/school performance	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Social/marital/family problems:	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Legal :	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Stressors: Orientation/alertness /awareness	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A		
Support System: (describe)			
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:			
CURRENT / PREVIOUS TREATMENT			
Is a psychiatrist involved in the member's care? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, when was the member last seen and what services are being rendered?			
History of hospitalization in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Facility :		Dates :	

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Is a therapist currently involved in the members care ? Yes No

Name of Current 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

Please list any other treatment received over the past two years :

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
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<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 :

ADDITIONAL CLINICAL INFORMATION

Is the member at risk of legal intervention or out-of-home placement? Describe :

Describe the overall risk of harm (to self or others) :

What are the environmental/community stressors and/or supports that contribute to the member's clinical status?

Describe the member/family engagement in treatment:

Expected Discharge date:

Detail the discharge plan: