



# Behavioral Health Service Request Form

## Inpatient, Subacute and CSU Services

<b>Georgia Medicare</b>
<b>Call for Pre-certification of Admissions</b>
<b>1-855-538-0454</b>
<b>Please Submit to the Dedicated Fax Line Below</b>
<b>Medicare Only Members: 1-877-892-8213</b>
<b>Dual Eligible Members (Members with Medicare &amp; Medicaid Policies): 1-855-292-0233</b>
<b>Discharge Planning: 1-855-776-9464</b>

<input type="checkbox"/>	<b>Retro Request</b>	Please indicate if the services are completed and the member is no longer in Inpatient care. Please submit the member record for review.
<b>Level of Care:</b>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Subacute <input type="checkbox"/> CSU	
<b>Place of Service:</b>	<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 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	REV/HCPCS Code(s)
Service Type:	REV/HCPCS Code :
Detox	
Rehab	



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Service Request Start Date:	Projected Length of Stay:	Original Admission Date (if different from Start Date Requested):	Transition of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No	Continuation of Care: <input type="checkbox"/> Yes <input type="checkbox"/> No
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### DIAGNOSIS - Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnoses	

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

### REASON FOR ADMISSION

Presenting problem to be addressed by treatment plan:

Date problem began		Duration		Is member under the care of a psychiatrist	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Is member currently inpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what is the current length of stay?
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Is member currently receiving Outpatient services?  
 Yes  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

I acknowledge that I am required to send a report of the member's admission to inpatient services to their PCP, and I will update their PCP quarterly.

### 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 checked yes above, 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:		



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### CURRENT IMPAIRMENTS

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed

Check the impairment level for each category and please provide brief description of any severe (3) impairments.

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 past 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	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
Orientation/alertness/awareness	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

### CURRENT/PREVIOUS TREATMENT

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?

History of hospitalization in the past year?    Yes    No

Name of Facility	Dates

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



# Behavioral Health Service Request Form

## Inpatient, Subacute and CSU Services

### 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

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?

Support System ( describe ):

Describe the member/family engagement in treatment:

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

Detail the discharge plan: