



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	<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

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?	<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	



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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?	<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 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.**