Request information

Requested start date for this request:

Admit Date:

Level of Care: ☐ Inpatient (when allowed by contract) ☐ 23 hr. ☐ CSU

☐Partial ☐Residential ☐ IOP/SOP ☐Group Home ☐Halfway House

☐Other

Type of Review: ☐Prospective ☐Concurrent ☐Discharge

☐Retrospective

Type of Care: ☐Mental Health ☐ Substance Use ☐Detox

Member Demographics

Member Name:

Date of Birth: Member/Policyholder ID:

Member's City/State: Tel #:

Subscriber's Employer / Benefit Plan:

Facility Information

Name: Facility ID #:

Service Address/City/State:

Attending Provider: Tel #:

UR Name: Tel #:

UR fax:

Clinical and Treatment Information

Is the Member currently waiting in the ER? ☐Yes ☐ No

Symptomatology leading to request/reason for current admit request:

Behavioral diagnosis (ICD code and DSM name):

Medical diagnosis (ICD code and name):

Social elements impacting diagnosis:

Optional Assessment: Tool Score

Are there any comorbid medical conditions that impact treatment of the MH/SUD conditions? ☐ Yes ☐ No ☐ Unknown

Is the individual receiving appropriate medical care for the medical conditions? ☐Yes ☐ No ☐ Unknown

Current Risk: *Risk level scale: 0= none; 1=mild; 2 moderate, ideation with either plan or history of attempts; 3=severe, ideation AND plan with either intent or means*

Risk to self /SI: ☐ 0 ☐ 1 ☐ 2 ☐ 3

Risk to others/ HI: ☐ 0 ☐ 1 ☐ 2 ☐ 3

SUD risk level scale: 0=non, 1= mild, 2= moderate, 3= severe

Substance use: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ not assessed

Primary issues/symptoms addressed in treatment for this request:

☐ danger to self ☐ danger to others ☐ psychosis ☐child/adolescent behavior ☐ eating disorder ☐ neurocognitive ☐ substance use ☐ mood disorder ☐other, describe

Describe presenting problem, additional details around primary symptoms, history of issue, care management needs, and other info pertinent to member's history and current request:

Member Name: Member ID #

Please list current psychotropic meds, start date, dosage, any another pertinent med info such as adherence, effectiveness, concerning side effects, target symptoms:

Urine drug screen completed ☐Yes ☐No ☐Unknown

If yes, UDS date Outcome ☐positive ☐negative ☐pending

If positive check all that apply: ☐cannabis ☐opiates ☐cocaine ☐ amphetamines ☐ tricyclic antidepressants ☐ phenylpropanolamine ☐ benzodiazepines ☐barbiturates ☐ methamphetamine ☐ PCP ☐LSD ☐ Methadone ☐Other

Blood alcohol

ASAM dimensions (required for SUD services or primary SUD diagnosis)

Intoxicated/WD potential: ☐low ☐med ☐high

Biomedical conditions: ☐low ☐med ☐high

Emotional/Beh/Cog Conditions: ☐low ☐med ☐high

Readiness to change: ☐low ☐med ☐high

Relapse potential: ☐low ☐med ☐high

Recovery environment: ☐low ☐med ☐high

Please outline the recovery and resiliency supports such as strengths, support systems, recovery environment as well as supports to be put in place:

Attestations and DC Planning

I endorse that I follow Best Practice Guidelines for the Primary Behavioral Diagnosis: ☐Yes ☐No

I, the provider, agree to verbally inform the Member of this authorization determination once known: ☐ Yes ☐ No

Discharge planning should include coordination of care with current and follow up providers. Discharge and transition planning should be part of treatment throughout the stay. HEIDIS measures should be followed.

Expected DC date: Est return to work date:

Planned DC level of care: ☐outpatient ☐inpatient ☐CSU ☐residential ☐partial ☐IOP/SOP ☐group home ☐halfway home ☐ Other

Planned DC residence: ☐home ☐nursing home/SNF/ asst living ☐group home/ halfway house ☐shelter ☐correctional facility ☐foster care ☐ respite ☐state hospital ☐residential ☐juvenile detention ☐transfer to med unit ☐transfer to alt psych facility ☐other

Signature/date:

Member Name: Member ID #

For Discharge Notices

Actual DC date: Primary diagnosis

DC condition: ☐improved ☐no change ☐worse

Treatment involved the following: ☐adverse incident ☐child protection ☐EAP ☐family ☐legal system ☐OP provider ☐PCP ☐other support system

DC plans in place: ☐Yes ☐No

If no, please explain further:

Type of DC: ☐planned ☐AMA

Actual DC level of care: ☐outpatient ☐inpatient ☐23 hr ☐CSU ☐ residential ☐partial ☐IOP/SOP ☐group home ☐halfway house ☐ other

Actual DC residence: : ☐home ☐nursing home/SNF/ asst living ☐group home/ halfway house ☐shelter ☐correctional facility ☐foster care ☐ respite ☐state hospital ☐residential ☐juvenile detention ☐transfer to med unit ☐transfer to alt psych facility ☐other

Follow-Up Contact Information

Name of Member or family member who is primary contact for follow up:

Relationship to member:

Phone #: email:

Aftercare behavioral health provider name:

☐not arranged ☐unknown

BH provider phone #:

Scheduled apt date: time:

Type of apt: ☐mental health ☐substance use ☐med mgmt.

Prescribing Practitioner Name:

☐not arranged ☐unknown

Prescriber phone #:

Prescriber type: ☐PCP ☐psychiatrist ☐other

Scheduled apt date: time:

Name of person completing this form:

Signature/date: