Behavioral Health Service Request Form

Detox and Substance Abuse Rehab

Georgia Medicare
Call for Pre-certification of Admissions
1-855-538-0454
Please Submit to the Dedicated Fax Line Below
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

Level of Care:	☐ Detox ☐ Substance Abuse Rehab
Place of Service:	☐ 21- Inpatient Hospital ☐ 51- Inpatient Psychiatric Hospital ☐ 55- Residential Substance Abuse Treatment Facility ☐ 56- Psychiatric Residential Treatment Center

MEMBER INFORMATION					
Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**Wellcare ID Number**		**Gender**	☐ Male ☐ Female
Third-Party Insurance	☐Yes ☐ 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**	☐Yes ☐ 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/HCPS Code :**			
Detox				
Rehab				
Service Request Start Date:	**Projected Length of Stay:**	**Original Admission Date (if different from Start Date Requested):**	**Transition of Care:** ☐ Yes ☐ No	**Continuation of Care:** ☐ Yes ☐ No

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Symptom	Rating		Symptom	Rating	
Nausea and Vomiting	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Agitation	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Tremor	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Generalized Anxiety	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Paroxysmal Sweats	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Visual Disturbances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Unstable Vital Signs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Memory Impairment	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Delusions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Impaired Judgement	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Tactile Disturbances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Headache, Fullness in Head	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Auditory Disturbances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Orientation and Clouding of Sensorium	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Socially Withdrawn/Isolating	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Interpersonal Conflict (hostile, intimidating)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Poor Impulse Control	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Cravings/Preoccupation with Substances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Drug Seeking Behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Work/School Problems	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	

Suicidal/Homicidal: ☐ Ideation ☐ Plan ☐ Means (Include previous attempts and dates)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Hallucinations: ☐ Auditory ☐ Visual ☐ Command (Include examples and dates)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

CURRENT/PREVIOUS TREATMENT

Indicate if any of the following are involved in the member's care and list Provider:

Psychiatrist: ☐ Yes ☐ No **Provider:** **PCP:** ☐ Yes ☐ No **Provider:**

Integrated Health Home: ☐ Yes ☐ No **Provider:**

If yes, when was the member last seen and what services are being rendered?

Is member currently receiving Outpatient services? ☐ Yes ☐ No

Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment? ☐ Yes ☐ No

Level of Care	Name or Provider / Facility	Dates	Successful
Inpatient / Detox:			☐ Yes ☐ No
Substance Abuse Rehab:			☐ Yes ☐ No
IOP/PHP:			☐ Yes ☐ No
Outpatient:			☐ Yes ☐ No

If treatment was not successful, please explain:

Please explain why the member cannot be managed safely in a less intensive level of care:

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

Name of Provider/Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

SUPPORT SYSTEMS & PERFORMANCE

Relationship/Supports (Identify issues/concerns? Is support available? Is support substance free?)

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

Describe the member/family engagement in treatment:

Is the member at risk of legal intervention or out-of-home placement? ☐ Yes ☐ No (describe)

Role performance school/work:

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe:			

Detail the expected discharge plan:

ATTACHMENTS

☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other:

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CONTINUED STAY REVIEW

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the past week that support the need for residential care. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.

Continued symptoms/behaviors:

Current CIWA Score: (if applicable)	COW Score: (if applicable)	Current ASAM Dimension Scores (if applicable):	

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed
Check the impairment level for each category and provide a brief description:

Symptom	Scale	Description	Symptom	Scale	Description
Functioning	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Ability to follow instructions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Complete assignments	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Perform ADLs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Cravings/preoccupation with substances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Drug-seeking behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Withdrawal symptoms	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A				

Types of services offered	Total number of sessions attended	Total number of sessions missed	Is member cooperative with treatment?	Please provide an explanation of any 'no' responses
Individual Therapy			☐ Yes ☐ No	
Group Therapy			☐ Yes ☐ No	
Substance Abuse Counseling			☐ Yes ☐ No	
Family Therapy			☐ Yes ☐ No	
Psychiatric Interventions			☐ Yes ☐ No	

CURRENT MEDICATIONS (Psychotropic and Medical)

Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Are there any medication contraindications? If yes, please describe:

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Detail changes to the discharge plan:

ATTACHMENTS

☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other:

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