WellCare
Beyond Healthcare. A Better You.

Behavioral Health Service Request Form

Routine Outpatient Services

Medicaid
Kentucky 877-544-2007

Today's Date

Place of Service	☐ 11- Office ☐ 12- Home ☐ 13- Assisted-Living Facility ☐ 14- Group Home ☐ 20- Urgent Care Facility ☐ 22- On Campus–Outpatient Hospital ☐ 33-Custodial Care Facility ☐ 50- Federally Qualified Health Center ☐ 53- Community Mental Health Center ☐ 57- Non-residential Substance Abuse Treatment Facility ☐ 71- Public Health Clinic ☐ 72- Rural Health Clinic ☐ 99- Other place of service not identified above

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	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 Problems	

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.***

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Member Name (Last, First)	Today's Date

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?	☐	☐	☐

Current Severity Rating

Functional Area	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others	☐	☐	☐	☐	
Impairment of psychological functioning	☐	☐	☐	☐	
Impairment of social functioning (family/school/work)	☐	☐	☐	☐	
Impairment of physical functioning	☐	☐	☐	☐	
Impairment in support systems	☐	☐	☐	☐	
Other (list)	☐	☐	☐	☐	

If substance abuse identified, please provide details:

Substance name	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?	☐ Yes ☐ No	Adherent to medications?	☐ Yes ☐ No

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.**

Member Name (Last, First)	Today's Date