Behavioral Health Service Request Form

Targeted Case Management (TCM) T2023

☐ Please check here if request is for member with Substance Use Disorder. All authorization requests pertaining to the treatment of Substance Use Disorders will be processed in an expedited manner.

Medicaid

Kentucky Fax # – 1-877-544-2007

Place of Service	☐ 11- Office ☐ 12- Home ☐ 53- Community Mental Health ☐ [99]- Other place of service not identified above. Please specify:

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, please 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**	

REQUESTED START DATE	**REQUESTED NUMBER OF UNITS (NOT TO EXCEED 3 UNITS)**
	T2023 x ☐UA, ☐HE, ☐ TG, ☐ HF

DIAGNOSIS Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Problems	

ASAM Dimension Scores	**CASII Score**	**ECSII Score**	**LOCUS Score**

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

RATIONALE FOR REQUEST

Does the member receive medication management services? ☐ **Yes** ☐ **No When was member last seen?**

Medication:	**Dosage:**	**Frequency:**	**Compliant:**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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

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Summarize the care plan goals/interventions: (Leave blank if attaching a copy of the care plan.)
What will TCM services address in the next service period:
Response to services: (Please describe progress or lack of progress.)
Compliance with services: (If noncompliant, how will this be addressed?)
What is the Discharge Plan: **Expected Discharge Date:**

RATIONALE FOR REQUEST						
Circle the impairment level for each category and <u>give a brief description</u>. **Scale: 0=None; 1 = Mild; 2 = Moderate; 3 = Severe; N/A = Not Assessed**						
Risk of harm (S/I; self-harming behaviors; etc.):	**0**	**1**	**2**	**3**	**4**	**5**
Functional status Needs help with ADLs):	**0**	**1**	**2**	**3**	**4**	**5**
Comorbidities (S.A.; medical):	**0**	**1**	**2**	**3**	**4**	**5**
Environmental stressors (Domestic violence; transportation issues):	**0**	**1**	**2**	**3**	**4**	**5**
Support in the environment: (Who are the supports?)	**0**	**1**	**2**	**3**	**4**	**5**
Response to treatment: (If minimal response, how is the treatment plan being adjusted to address?)	**0**	**1**	**2**	**3**	**4**	**5**
Acceptance and engagement: (Does member/caregiver identify need for treatment and participate?)	**0**	**1**	**2**	**3**	**4**	**5**

*****Please submit a copy of the following and any additional supporting documentation for medical necessity review:**
Initial Request – most recent assessment; service plan
Concurrent Request – updated service plan; contact log