Behavioral Health Service Request Form

PHP and IOP Services as Covered

<Please Submit to the Dedicated Contract Fax Line Below>

Medicare (IOP is not a covered benefit)			Medicaid
Arizona- 888-834-8404	**Kentucky-**888-365-5676	**Ohio-** 855-710-0164	**Georgia-**888-871-0590
Arkansas – 855-710-0160	**Louisiana-** 855-710-0160	**South Carolina -** 855-710-0160	**Kentucky-**877-544-2007
Connecticut- 888-365-5607	**Mississippi** - 855-710-0160	**Tennessee -** 855-710-0160	**Illinois-** 855-713-0595
Florida- 855-710-0168	**Missouri-** 855-710-0162	**Texas-** 855-671-0259	**New Jersey-**888-339-2677
Georgia-855-710-0166	**New Jersey-**888-339-2677		**New York-** 855-713-0591
Illinois-855-713-0593	**New York-** 855-713-0589		

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan fourteen (14) days prior to the date the requested services will be performed.
☐	**Expedited Request**	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request

Date Signed

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/HCPCS Code(s) and Number of Each Requested		
PHP			
IOP			
Service Request Start Date:	**Service Request End Date:**	**Transition of Care** ☐**Yes** ☐ **No**	**Continuation of Care** ☐**Yes** ☐ **No**

DSM-IV DIAGNOSIS (AXIS I – V)

Primary Diagnoses		**R/O**	
Secondary Diagnoses		**R/O**	
Medical Problems			
Current GAF/CAFAS		**Highest GAF/CAFAS in Past Year**	
Current Total LOCUS/CALOCUS Score: (if applicable)		**Current ASAM Dimension Scores: (if applicable)**	

WellCare Health Plans

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CURRENT RISKS										
Circle the risk level for each category and check all boxes that apply.										
Risk to self (SI)	0	1	2	3	With ☐ ideation,	☐ intent,	☐ plan,	☐ means		
Risk to others (HI)	0	1	2	3	With ☐ ideation,	☐ intent,	☐ plan,	☐ means		
Current serious attempt or gesture	☐ Yes	☐ No (if yes, describe)							Circle: SI	HI
Date of most recent attempt or gesture:										
Prior serious attempt or gesture	☐ Yes	☐ No (if yes, describe)							Circle: SI	HI

IMPAIRMENT to ADLs			
Is member motivated for treatment?	☐ Yes ☐ No	Is Transportation available?	☐ Yes ☐ No
Relationships:			
Role performance school/work:			
Current living situation?			

ADDITIONAL DATA TO SUPPORT REQUEST	
Is a psychiatrist involved in the member's care? ☐ Yes ☐ No If yes, when was the member seen last and what services are being rendered?	
Any Previous Inpatient, Residential/Rehab, PHP, IOP, or Outpatient treatment? ☐ Yes ☐ No	
Name of Facility	Dates
Did prior treatment fail? ☐ Yes ☐ No (describe)	

SUPPORT SYSTEMS
Current Symptoms and behaviors:
Describe the overall risk of harm (to self or others):
What are the environmental/community stressors and/or supports that contribute to the member's clinical status?
Describe the member/family engagement in treatment:

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

CURRENT MEDICATIONS (Psychotropic and Medical)			
Medication	**Dosage**	**Frequency**	**Adherent?**
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Any medication contraindications? If yes, describe.			