



## Behavioral Health Service Request Form

Intensive Outpatient and Routine Outpatient Services as Covered

Please Submit to the Dedicated Account Fax Line Below:

Medicare (IOP is not a covered benefit)	Medicaid
<b>Arizona- 888-834-8404</b> <i>*No prior auth needed for routine outpatient services for PAR providers</i>	<b>Georgia- 888-871-0590</b> <i>*No prior auth needed for routine outpatient services for PAR providers</i>
<b>Connecticut- 888-365-5607</b> <i>*No prior auth needed for routine outpatient services for PAR providers</i>	<b>Kentucky- 877-544-2007</b> <i>*No prior auth needed for routine outpatient services for PAR providers</i>
<b>Kentucky- 888-365-5676</b> <i>*No prior auth needed for routine outpatient services for PAR providers</i>	

<input type="checkbox"/>	<b>Standard Request</b>	FOR OUT OF NETWORK PROVIDERS ONLY PRIOR AUTHORIZATION IS REQUIRED FOR ALL SERVICES. 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.
<input type="checkbox"/>	<b>Expedited Request</b>	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

### REQUEST TYPE

Initial	<input type="checkbox"/>	Recertification	<input type="checkbox"/>	Change	<input type="checkbox"/>	Authorization #		Request Date	
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### MEMBER INFORMATION

Last Name		First Name, Middle Initial		Date of Birth	
Phone Number		WellCare ID Number		Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male
Third Party Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> 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	

### ORDERING PHYSICIAN/PRACTITIONER INFORMATION

Last Name		First Name		NPI Number	
WellCare ID Number		Type	<input type="checkbox"/> PCP <input type="checkbox"/> Specialist	Specialty	
Participating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phone Number		Fax Number	
Street Address			City, State		Zip
Name of Requestor			Office Contact (If Different)		

### TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name		First Name		NPI Number	
WellCare ID Number		Participating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discipline/Specialty	
Street Address			City, State		Zip
Phone Number		Fax Number		Office Contact	

### FACILITY INFORMATION

Authorizations will be given for medically necessary services only; it is not a guarantee of payment. Payment is subject to verification of member eligibility and to the limitations and exclusions of the member's contract. Emergency care does not require prior authorization. An emergency is a medical condition manifesting itself by acute symptoms of sufficient severity which could result (without immediate medical attention) in serious jeopardy to the health of an individual. \*Urgent care is defined as medically necessary treatment for an injury, illness or type of condition (usually not life threatening) which should be treated within 24 hours. (Effective October 1, 2011)

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Name		Facility ID		NPI Number	
Street Address	City, State		Zip		
Phone Number	Fax Number	Office Contact			

### REQUESTED SERVICES

Start Date		End Date		Transition of Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Continuation of Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary CPT/ICD-9 or HCPS Code(s) and Hours/Units of Each Requested	Description/Condition						

Indicate any change in diagnostic presentation.

Axis I		R/O	
Axis II		R/O	
Axis III			
Axis IV (Psychological Stressors)			
Axis V – Current GAF		Highest GAF in Past Year	

### PRESENTING PROBLEM and PATIENT SYMPTOMOLOGY

Include the date the problem(s) began along with the duration		Psychiatrist involved in care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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### CURRENT SYMPTOMS: Check all that apply

<input type="checkbox"/> Suicidal/Homicidal Ideation	<input type="checkbox"/> Impaired Attention/Concentration	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Motoric Disturbance
<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Eating Problems	<input type="checkbox"/> Memory Impairment
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Oppositional	<input type="checkbox"/> Coping with pain	<input type="checkbox"/> Disorientation
<input type="checkbox"/> Hopelessness/Helplessness	<input type="checkbox"/> Tantrums	<input type="checkbox"/> Substance Abuse/Dependence	<input type="checkbox"/> Impaired Judgment
<input type="checkbox"/> Irritability	<input type="checkbox"/> Work/School Problems	<input type="checkbox"/> Rage/Anger	<input type="checkbox"/> Lack of Insight
<input type="checkbox"/> Anhedonia	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Phobia	<input type="checkbox"/> Distorted Thinking
<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Delusions	<input type="checkbox"/> Obsession/Compulsion	<input type="checkbox"/> Distrustful/Suspicious
<input type="checkbox"/> Verbal/Physical/Sexual Abuse	<input type="checkbox"/> Thought Disturbance	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Victim	<input type="checkbox"/> Pressured Speech	<input type="checkbox"/> Generalized Anxiety	<input type="checkbox"/> Fire setting
<input type="checkbox"/> Perpetrator	<input type="checkbox"/> Grandiosity	<input type="checkbox"/> Cruelty to animals	<input type="checkbox"/> Bed wetting
<input type="checkbox"/> Self-Mutilation			

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RATIONALE
<b>What is the purpose of treatment for this member? Include relevant history.</b>
<b>Identify the treatment goals.</b>
<b>Describe how the treatment plan will affected the treatment outcomes. (Please attach a copy of the current treatment plan)</b>
<b>Are there other reasons treatment is necessary?</b>
<b>Is this treatment court or research related or for admission to a program or school?</b>
<b>Has there been any prior outpatient treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify the dates).</b>
<b>Treatment failure? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify the previous treatment).</b>
<b>Current Medications (Please indicate if the member is compliant)</b>

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