INSTRUCTIONS
FOR
TRICARE South Behavioral Health
Higher Level of Care Treatment Report Form

WHEN YOU FAX IN A REVIEW, PLEASE USE A NEW FORM AS THE PATIENT'S CONDITION CONSTANTLY CHANGES. PLEASE TYPE OR LEGIBLY PRINT (USING DARK INK) ALL INFORMATION.

IF YOU KNOW THE NAME OF YOUR TRICARE - ValueOptions® REVIEWER PLEASE PUT THEIR NAME ON YOUR FAX COVER SHEET OR ON THE HIGHER LEVEL OF CARE DOCUMENT.

Level of Care: Each time you fax this document, please place an "X" in the Level of Care box. Only one box can be checked.

☐ **Inpatient Psych**

☐ **IP Detox**

☐ **IP Rehab. -** Needs to be pre-authorized prior to admission. Please attach the evaluation by a: Physician, ARNP or PA to the HLOC. This professional must have admitting privileges to the facility or program. **If the admission is a step down from an acute level of care, please attach the Doctor's written rationale to the HLOC**.

☐ **Full Day Psych PHP -** Needs to be pre-authorized prior to admission. Please attach the evaluation by a: Physician to the HLOC. This professional must have admitting privileges to the facility or program. **If the admission is a step down from an acute level of care, please attach the Doctor's written rationale to the HLOC**.

☐ **1/2 Day Psych PHP -** Needs to be pre-authorized prior to admission. Please attach the evaluation by a: Physician to the HLOC. This professional must have admitting privileges to the facility or program. **If the admission is a step down from an acute level of care, please attach the Doctor's written rationale to the HLOC**.

☐ **CD-PHP- Full Day -** Needs to be pre-authorized prior to admission. Please attach the evaluation by a Physician, ARNP or PA to the HLOC. This professional must have admitting privileges to the facility or program. **If the admission is a step down from an acute level of care, please attach the Doctor's order to the HLOC.**

☐ **1/2 Day CD PHP -** Needs to be pre-authorized prior to admission. Please attach the evaluation by a Physician, ARNP or PA to the HLOC. This professional must have admitting privileges to the facility or program**. If the admission is a step down from an acute level of care, please attach the Doctor's order to the HLOC.**

Type of Review: **Each** time you fax the document please put an "X" in the appropriate box.

- **Initial-**This is your first fax/review. This is your initial request for authorization for treatment.

- **Concurrent**-These are fax reviews after the initial review. We have already authorized the admission and you are faxing us updates. Please fax in a new HLOC document for each update.

- **Discharge**-This is information you will fax to us telling us the patient is discharged and specific information related to the discharge. Please fax in a new HLOC document for the discharge.

Patient Name: First Name, Middle Initial (if applicable), and Last Name.

Date of Birth: Month/Date/Year of the patient's birth.

Contact Phone Number: Patient's contact phone number.

Sponsor's SSN: **SSN OF THE SPONSOR, NOT THE PATIENT, UNLESS THE PATIENT IS THE SPONSOR**. A sponsor is the policy holder-- active duty military, retired military or disabled former military. * Former spouses who retain benefits will be eligible under their own SSN.

Facility: The full name of your hospital or facility.

Facility Tax ID: The facility/hospital Tax I.D. **(including any applicable suffixes).**

Attending Provider: First and Last Name of the Doctor who will be attending to the patient's care.

Attending's Phone: Phone number of the attending's office, (our physician may need to call the attending, we will notify you first).

UR Contact: Name of the person at the hospital/facility that will be working with us for continued stay fax reviews.

UR Contact Phone Number: Phone number and ext. (if applicable), of the person at the hospital/facility that will be working with us for continued stay fax reviews.

Fax: Fax number and of the person at the hospital/facility that will be working with us for continued stay fax reviews.

Substance Abuse/ Dependence: If the **patient is not dependent on or abusing substances (to include alcohol),** please check "No" and do not fill out the two (2) boxes under substance dependence. Please continue with the box "Drug Screen" and proceed downward.

If the **patient is currently dependent on or abusing substances (to include alcohol**), please check "Yes" and proceed downward to complete the next three boxes:

Substance-Name of substance?

Length of Current Use**:** How long has the patient been abusing the substance? (e.g. - Past 2 years; Past 6 months, etc)

Amount: How much is the patient drinking/using?

Frequency: How often is the patient drinking/using?

Date Last Used: When is the last time the patient drank/used?

Withdrawal Symptoms: Check the "None" box or check those symptoms that are applicable.

Drug Screen: Check "Yes" or "No". If yes, please document the date the drug screen was taken and the results of the drug screen.

Discharge Information: Please check the applicable box, document the date of discharge and the total number of days use for inpatient/php program.

Date/Time of the first follow-up appointment: Document the date and time of the first (earliest) follow-up appointment followed by the date and time of the next follow-up appointment, if applicable. **** Follow-up appointment(s) should take place within 7 days of the date of discharge ****

Follow up Provider/Facility: The earliest follow up appointment listed on date and time will correspond here with the name and credentials of the provider followed by the name of the next appointment with the name and credentials of the provider if applicable.

If the follow up appointment is with another facility or a program within your facility, document the name of the facility and program (e.g. Fazoo Medical Center-CD-PHP Full Day). The date of the first appointment and time will be documented in the Date and Time in the first follow-up section of the discharge information box.

Follow-up Provider/Facility Phone Number: As indicated with the phone number of the provider who has the earliest appoint, etc.

ICD-9 Diagnosis Codes and Axis –

**** The diagnosis must relate to the level of care that is being requested when the Initial/Admission fax is sent to us.**
**** If the diagnosis has changed during the concurrent review process or at discharge, please document the change in the appropriate Axis ****

Treatment Admit Date: The formal date the patient was admitted to your hospital/facility.

Time: The time the patient was admitted to the unit or program.

Voluntary/Involuntary: Self explanatory.

Discharge Plan: Should be documented on admission and for concurrent reviews. **Discharge planning begins at admission.**

Anticipated date of discharge – IMPORTANT- At each fax review please fill this out.

Current Psychotropic Medication / Dosing / Schedule: For admission, concurrent and discharge reviews, list only psychotropic medications.

Current Rationale for Admission / Continued Stay: **THIS IS VERY IMPORTANT**.

- **For the initial/admission review fax -** what is the rationale for the admission- medical/clinical documentation from the professional who evaluated the patient and determined that the admission was clinically and medically appropriate?

  Clarification/explanation of dangerousness (suicidal/homicidal/violence, aggression as evidenced by XXX) or psychosis (as evidenced by XXX) is very helpful here. "Intoxicated" or "Impending withdrawal" or "Exhibiting signs and symptoms of withdrawal" (utilize the withdrawal check list on left side of the HLOC). Why can't the patient be treated outside of the acute hospital?

  Please note that you may also fax the admission evaluation note as an attachment to the HLOC document.

- **For Continued Stay/Concurrent reviews-** what is the rationale for the patient to remain in the current level of care?

  Clarification/explanation of dangerousness (suicidal/homicidal/violence, aggression as evidenced by XXX) or psychosis (as evidenced by XXX) is very helpful here. "Withdrawal signs and symptoms continue" (utilize checklist on left side of the HLOC). Why can't the patient be treated outside of the acute hospital setting?

  Please note that you may also fax the physician's rounding note(s) as an attachment to the HLOC document.

TRICARE BEHAVIORAL HEALTH: Higher Level of Care Treatment Report

Fax To: 1-866-811-4422

VALUEOPTIONS

TRICARE

Level of Care: ☐ INPATIENT PSYCH ☐ IP REHAB ☐ CD-PHP-FULL DAY ☐ 1/2 DAY CD-PHP
☐ IP DETOX ☐ PSYPH PHP-FULL DAY ☐ 1/2 DAY PSYCH PHP

Type of Review: ☐ Initial ☐ Concurrent ☐ Discharge

Patient Name: _____

Date of Birth: _____ **Contact Phone Number:** _____

Sponsor's I.D. (Not the patient's SSN): _____

Facility Name: _____

Facility Tax ID (with suffix-if applicable): _____

Attending Provider: _____

Attending's Phone: _____

UR Contact: _____

UR Contact Phone Number: _____ **Fax:** _____

Axis I: _____

Axis II: _____

Axis III: _____

Treatment Admit Date: _____ **Time:** _____ **Voluntary** ☐ **Involuntary** ☐

Discharge Plan: _____

Anticipated date of discharge:

Substance Abuse/ Dependence: ____No ____Yes (If yes, complete below)

Substance	Length Current Use	Amount	Frequency	Date of Last Use

Withdrawal Symptoms: *Check all that apply.* ☐ None

Nausea	☐	Tremors	☐	Vitals (*If detox or relevant*):	
Vomiting	☐	Blackouts	☐	BP:	
Cramping	☐	Current DTs	☐	Temp:	
Sweating	☐	Past DTs	☐	Pulse:	
Agitation	☐	Current seizure	☐	Resp:	
Hallucinations	☐	Past seizures	☐	BAL/Breathalyzer:	

Drug Screen: __No __Yes **Date:** **Results:**

Discharge Information

☐ Child Protective Service ☐ AMA ☐ Home

D/C Date: _____ **Total # Days/Session Used:** _____

Date / Time of first follow-up appointment (within 7 days of discharge):

Follow-up Provider/Facility: _____

Circle as appropriate: MD Ph.D. Social Worker Master's Level Therapist

Follow-up Provider / Facility Phone number:

Current Psychotropic Medication / Dosing / Schedule ** Update at discharge also**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Current Rationale for Admission / Continued Stay (Specify suicidal/homicidal/violence/psychosis):

If needed attach additional pages

** All treatment is subject to medical necessity determination and is based on beneficiary eligibility. Submission of form does not automatically constitute authorizations.*

** Please contact TRICARE South Behavioral Health for assistance at 800-700-8646 with discharge planning or other needs.*

***PHPs: ON EACH CONCURRENT REVIEW AND DISCHARGE, NEED ALL DATES ATTENDED FOR 1/2 DAY OR FULL DAY.**

Rev: 6/2011