

## ***Behavioral Health Initial Review Form for Inpatient and Partial Hospital Programs***

Instead of faxing this form, submit your request electronically using our preferred method at <https://www.availity.com>.\* If you use this form, fax it to **1-844-430-1702**.

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|--|--|
| Today's date:  |  |
| <b>Contact information</b>                             |  |
| Level of care:   |  |
| <input type="checkbox"/> Inpatient psychiatric         | <input type="checkbox"/> Inpatient detox   |
| <input type="checkbox"/> PHP mental health             | <input type="checkbox"/> PHP substance use |
| <input type="checkbox"/> Inpatient substance use rehab |  |
| Member name:   |  |
| Member ID or reference #:                              | Member DOB:                                |
| Member address:  |  |
| Member phone:  |  |
| Hospital account #:                                    |  |
| For child/adolescent, name of parent/guardian:         |  |
| Primary spoken language:                               |  |
| Name of utilization review (UR) contact:               |  |
| UR contact phone number:                               | UR contact fax number:                     |
| Admit date:  |  |
| Admitting facility name:                               | Facility provider # or NPI:                |
| Attending physician (first and last name):             |  |

\* Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup.

**<https://providers.amerigroup.com>**

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| Attending physician phone:   | Provider # or NPI: |
| Facility unit:   | Facility phone:    |
| Discharge planner name:  |                    |
| Discharge planner phone:   |                    |
| <b>Diagnosis (psychiatric, chemical dependency and medical)</b>  |                    |
|  |                    |
| <b>Precipitant to admission (Be specific. Why is the treatment needed now?)</b>  |                    |
|  |                    |
| <b>Risk of harm to self</b>  |                    |
| If present, describe:  |                    |
|  |                    |
| If prior attempt, date and description:  |                    |
|  |                    |
| Risk rating (Select all that apply.)   |                    |
| <input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior attempt |                    |
| <b>Risk of harm to others</b>  |                    |
| If present, describe:  |                    |
|  |                    |
| If prior attempt, date and description:  |                    |
|  |                    |
| Risk rating (Select all that apply.)   |                    |
| <input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior attempt |                    |

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| <b>Psychosis</b>  |  |
| Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):  |  |
| <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A  |  |
| If present, describe:   |  |
| Symptoms (Select all that apply.):  |  |
| <input type="checkbox"/> Auditory/visual hallucinations <input type="checkbox"/> Paranoia<br><input type="checkbox"/> Delusions <input type="checkbox"/> Command hallucinations   |  |
| <b>Substance use</b>  |  |
| Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):  |  |
| <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A  |  |
| Substance (Select all that apply.):   |  |
| <input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine<br><input type="checkbox"/> PCP <input type="checkbox"/> LSD <input type="checkbox"/> Methamphetamines<br><input type="checkbox"/> Opioids <input type="checkbox"/> Barbiturates <input type="checkbox"/> Benzodiazepines<br><input type="checkbox"/> Other (Describe.): |  |
| Urine drug screen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  |
| Result (if applicable):   |  |
| <input type="checkbox"/> Positive (If selected, list drugs.): <input type="checkbox"/> Negative <input type="checkbox"/> Pending  |  |
| BAL: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  |
| Result (if applicable): <input type="checkbox"/> Value: <input type="checkbox"/> Pending  |  |
| Substance use screening (Select if applicable and give score.):   |  |
| <input type="checkbox"/> CIWA: <input type="checkbox"/> COWS:   |  |
| <b>For substance use disorders, please complete the following additional information.</b>   |  |
| <b>Current assessment of American Society of Addiction Medicine (ASAM) criteria</b>   |  |
| <b>Dimension (Describe or give symptoms.)</b>   | <b>Risk rating</b>   |
| Dimension 1 (acute intoxication) and/or withdrawal potential (such as vitals, withdrawal symptoms)  | <input type="checkbox"/> Minimal/none — not under influence; minimal withdrawal potential<br><input type="checkbox"/> Mild — recent use but minimal withdrawal potential<br><input type="checkbox"/> Moderate — recent use; needs 24-hour monitoring<br><input type="checkbox"/> Significant — potential for or history of severe withdrawal; history of withdrawal seizures<br><input type="checkbox"/> Severe — presents with severe withdrawal, current withdrawal seizures |

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| <p>Dimension 2 (biomedical conditions and complications)</p>          | <ul style="list-style-type: none"> <li><input type="checkbox"/> Minimal/none — none or insignificant medical problems</li> <li><input type="checkbox"/> Mild — mild medical problems that do not require special monitoring</li> <li><input type="checkbox"/> Moderate — medical condition requires monitoring but not intensive treatment</li> <li><input type="checkbox"/> Significant — medical condition has a significant impact on treatment and requires 24-hour monitoring</li> <li><input type="checkbox"/> Severe — medical condition requires intensive 24-hour medical management</li> </ul>  |
| <p>Dimension 3 (emotional, behavioral or cognitive complications)</p> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Minimal/none — none or insignificant psychiatric or behavioral symptoms</li> <li><input type="checkbox"/> Mild — psychiatric or behavioral symptoms have minimal impact on treatment</li> <li><input type="checkbox"/> Moderate — impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs</li> <li><input type="checkbox"/> Significant — suicidal/homicidal ideations, behavioral or cognitive problems or psychotic symptoms require 24-hour monitoring</li> <li><input type="checkbox"/> Severe — active suicidal/homicidal ideations and plans, acute psychosis, severe emotional lability or delusions; unable to attend to ADLs; psychiatric and/or behavioral symptoms require 24-hour medical management</li> </ul> |
| <p>Dimension 4 (readiness to change)</p>                              | <ul style="list-style-type: none"> <li><input type="checkbox"/> Maintenance — engaged in treatment</li> <li><input type="checkbox"/> Action — committed to treatment and modifying behavior and surroundings</li> <li><input type="checkbox"/> Preparation — planning to take action and is making adjustments to change behavior; has not resolved ambivalence</li> <li><input type="checkbox"/> Contemplative — ambivalent; acknowledges having a problem and beginning to think about it; has indefinite plan to change</li> <li><input type="checkbox"/> Precontemplative — in treatment due to external pressure; resistant to change</li> </ul>   |

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| <p>Dimension 5 (relapse, continued use or continued problem potential)</p>   | <p><input type="checkbox"/> Minimal/none — little likelihood of relapse</p> <p><input type="checkbox"/> Mild — recognizes triggers; uses coping skills</p> <p><input type="checkbox"/> Moderate — aware of potential triggers for MH/SA issues<br/>but requires close monitoring</p> <p><input type="checkbox"/> Significant — not aware of potential triggers for MH/SA issues; continues to use/relapse despite treatment</p> <p><input type="checkbox"/> Severe — unable to control use without 24-hour monitoring; unable to recognize potential triggers for MH/SA despite consequences</p>                          |
| <p>Dimension 6 (recovery living environment)</p>   | <p><input type="checkbox"/> Minimal/none — supportive environment</p> <p><input type="checkbox"/> Mild — environmental support adequate but inconsistent</p> <p><input type="checkbox"/> Moderate — moderately supportive environment for MH/SA issues</p> <p><input type="checkbox"/> Significant — lack of support in environment or environment supports substance use</p> <p><input type="checkbox"/> Severe — environment does not support recovery or mental health efforts; resides with an emotionally/physically abusive individual or active user;<br/>coping skills and recovery require a 24-hour setting</p> |
| <p>If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?</p>   |   |
| <p><b>Previous treatment</b> (Include provider name, facility name, medications, specific treatment/levels of care and adherence.)</p> |   |
| <p><b>Current treatment plan</b></p> <p>Standing medications:</p>  |   |
| <p>As-needed medications administered (not ordered):</p>   |   |

Other treatment and/or interventions planned (including when family therapy is planned):

**Support system** (Include coordination activities with case managers, family, community agencies and so on. If case is open with another agency, name the agency, phone number and case number.)

**Results of depression screening**

Readmission within the last 30 days?  Yes  No  
If yes, and readmission was to the discharging facility, what part of the discharge plan did not work and why?

**Initial discharge plan** (List name and number of discharge planner and include whether the member can return to current residence.)

Planned discharge level of care:

Describe any barriers to discharge:

Expected discharge date:

**Submitted by:**

**Phone:**