Behavioral Health Psychiatric Residential Treatment Facilities Initial Review Form[SA1] [SA2]

Please submit this form electronically using our preferred method by logging onto Availity from the Amerigroup District of Columbia, Inc. provider website at https://providers.amerigroup.com/DC. This form can also be submitted via fax to 1-877-434-7578 on the last authorized day.

Today's date:		
Contact information		
Patient name:	Patient ID or reference #:	Patient DOB:
Patient address:	Patient phone #:	
For child or adolescent, name of parent or guardian:	Primary spoken language:	
Facility or provider submitting clinical review:	Requested practice management information corporation (PMIC) (if applicable):	
Requested PMIC admit date:	Patient's current location:	
Can patient return to current location (if applicable)?		
For patients with home- and community-based services waivers, please include support coordinator or targeted case manager information.		
EPSDT support coordinator name:	EPSDT support coordinator phone:	EPSDT support coordinator fax:
Clinician or doctor who can provide PMIC review and signed CON (if needed):	Clinician or doctor's phone number:	
Name of person completing form:	Phone number of person completing form:	

Diagnosis: psychiatric, chemical dependency and medical
Precipitant to admission: Be specific — Why is practice PMIC level of care needed?
Clearly document behaviors occurring in the previous three months.
Barriers to treatment progress — if admitted.

Current legal issues
Is enrollee in a juvenile detention center? Has the enrollee had an adjudication hearing — If so, what is the date? Is the enrollee in jail?
Substance use or dependence: current urinary analysis or lab results
Previous treatment
Include provider name, facility name, medications, specific treatment or levels of care and adherence. Please attach current psychological treatment. Be specific: previous inpatient, PMIC, group care, partial hospitalization program, intensive outpatient program, behavioral health intervention services, therapy (individual and family), medication management, intensive community supports, etc. — What are the dates of service and provider names?

Current treatment plan
Medications:
As-needed medications administered:
Other treatment or interventions planned — including when family therapy is planned:
Support system
Include coordination activities with case managers, family, community agencies, etc. If case is open with another agency, name the agency, phone number and case number.

Social history
Include school, family and community, behavioral issues, developmental issues, and IEP.
Initial discharge plan
List name and number of discharge planner, name of providers, addresses, and phone numbers.
Days requested for this review:
Expected length of stay from today:

Submitted by:	**Phone number:**

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.