Amerigroup RealSolutions in healthcare
Amerigroup STAR+PLUS MMP
(Medicare-Medicaid Plan)

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice
MMP

Behavioral health concurrent review fax form

For Amerigroup STAR+PLUS Medicare-Medicaid Plan (MMP) program

Please fax this form to [1-877-434-7578] on the last authorized day.

Today's date:		
Contact information		
Member name:	Member ID or reference number:	Member date of birth:
Member address:		Member phone number:
Facility contact name and phone number (if changed):		Name of facility:
Facility NPI or Amerigroup number:	Facility unit and phone number (if changed since initial review):	
Diagnosis (Document changes only)		
Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V:		
Risk assessment		
In the past 24 to 48 hours, has the member shown suicidal or homicidal thoughts or plans, physical aggression to self or others, or command auditory hallucinations; on close observation, drug and/or alcohol withdrawal symptoms or comorbid health concerns?		
If yes, explain:		
Lab results		
Medications List current medications and any changes with dates. Include medications for physical conditions. If medications require prior authorization, indicate how this is being addressed. Indicate as-needed [PRN] medications actually administered and when.		

Amerigroup STAR+PLUS MMP (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Texas Medicaid to provide benefits of both programs to enrollees.

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Summary of nursing notes:
Summary of MD notes:
Other treatment plan changes or assessments (Include results of chemical dependency assessment, medical assessments or treatments):

For substance use disorders (primary or secondary), complete the following additional information:

Current assessment of American Society of Addiction Medicine Patient Placement Criteria (PPC-2R)	
Dimension (Describe or give symptoms)	**Level of severity**
Dimension I (Intoxication/withdrawal potential)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):
Dimension II (Biomedical conditions)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):
Dimension III (Emotional/behavioral/cognitive)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):
Dimension IV (Readiness to change)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):
Dimension V (Relapse/continued use potential)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):
Dimension VI (Recovery environment)	High: ☐ Medium: ☐ Low: ☐ Explanation (if other than low):

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If any ASAM dimensions are high, how are they being addressed in treatment or discharge planning?
Response to treatment:
Involvement in treatment or discharge planning of member, family/guardian(s), outpatient providers or other identified supports:
Discharge planning (Note changes, barriers to discharge planning in these areas and plan for resolving barriers.)
Housing issues:
Psychiatry:
Therapy and/or counseling:
Medical:
Wraparound services:
Substance abuse services:
Was post-hospital discharge appointment scheduled? ☐ **Yes** ☐ **No** **Appointment date:**
Days requested or expected length of stay from today:

Submitted by:	**Phone number:**