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

STAR+PLUS PROGRAM
Your Health Plan ■ Your Choice
MMP

Behavioral health inpatient initial review form

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

Please fax this form to 1-877-434-7578 within 2 hours of admission.

Today's date:		
Contact information		
Member name:	Member ID or reference number:	Member date of birth:
Member address:		Member phone number:
Hospital account number:	For child/adolescent, name of parent/guardian:	Primary spoken language:
Name of utilization review contact:	Utilization review contact phone number:	
Admit date:	Level of care:	Voluntary or involuntary?
Facility name:	Facility NPI or Amerigroup provider number:	
Attending physician name:	Attending physician phone number:	
Provider NPI or Amerigroup provider number:	Facility unit:	Facility phone number:
Discharge planner name:	Discharge planner phone number:	
Diagnosis (All five Axes)		
Axis I:		
Axis II:		
Axis III:		
Axis IV:		
Axis V:		
Precipitant to admission Be specific. Why is the treatment needed <u>now</u>?		
Risk assessment Include medical necessity reasons for admission.		

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.

Current legal issues
Substance abuse or dependence Current UA/lab results
Previous treatment Include provider name, facility name, medications, specific treatment/levels of care and adherence.
Current treatment plan
Standing medications:
As-needed (PRN) medications administered (not ordered):
Other treatment and/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 and case number.)
Readmission within 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.
Days requested or expected length of stay from today:

Submitted by:	**Phone:**

Important Note: Please remember that, per HIPAA, you are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating or do not have 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.