Amerigroup

Medicare Advantage

Behavioral Health Concurrent Review Form for Inpatient and Partial Hospital Programs

Please submit your request electronically using our preferred method at **https://availity.com**.*
You may also fax this form to **844-430-1702**.

Today's date:			
Level of care			
☐ Inpatient mental health	☐ PHP substance abuse	☐ PHP mental health	
☐ IOP substance abuse	☐ IOP mental health		
Contact information			
Member name:		DOB:	
Member address:			
Member ID or reference #:		Member phone number:	
Facility account #:			
For child/adolescent, name of parent/guardian:			
Primary spoken language:			
Name of utilization review (UR) contact:			
UR phone number:		UR fax number:	
Admit date:	☐ Voluntary ☐ Involuntary		
If involuntary, date of commitment:		Facility provider # or NPI:	
Admitting facility name:			
Attending physician (first and last names):			
Attending physician phone number:		Facility unit:	
Provider # or NPI:		Facility phone number:	
Discharge planner name:			
Discharge planner phone number:			

Diagnoses (psychiatric, chemical dependency, and medical)

Risk of harm to self (within last 24 to 48 hours)	**Risk rating (check all that apply)**
If present, describe: If prior attempt, date and description:	☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

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

https://provider.amerigroup.com

Risk of harm to others (within last 24 to 48 hours)	**Risk rating (check all that apply)**
If present, describe: If prior attempt, date and description:	☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt
Psychosis (within last 24 to 48 hours) (risk rating: 0 = none; 1 = mild or mildly incapacitating; 2 = moderate or moderately incapacitating; 3 = severe or severely incapacitating; n/a = not assessed)	**Symptoms (check all that apply)**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A If present, describe:	☐ Auditory/visual hallucinations ☐ Paranoia ☐ Delusions ☐ Command hallucinations
Substance use (risk rating: 0 = none; 1 = mild or mildly incapacitating; 2 = moderate or moderately incapacitating; 3 = severe or severely incapacitating; n/a = not assessed)	**Substance (check all that apply)**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A If present, describe last use, frequency, duration, sober history:	☐ Alcohol ☐ Marijuana ☐ Cocaine ☐ LSD ☐ Methamphetamines ☐ Opioids ☐ Barbiturates ☐ PCP ☐ Benzodiazepines ☐ Other (describe):

Current treatment plan

Medications
Have medications changed (type, dose, and/or frequency) since admission? ☐ Yes ☐ No If yes, give medication, current amount, and change date: Have any PRN (pro re nata) or *as needed* medications been administered? ☐ Yes ☐ No If yes, give medication, administration date, and current amount:

Member's participation in and response to treatment						
Attending groups?			☐ Yes	☐ No	☐ N/A	
Family or other supports involved in treatment?			☐ Yes	☐ No	☐ N/A	
Adherent to medications as ordered?			☐ Yes	☐ No	☐ N/A	
Member is improving in (check all that apply):						
☐ Thought processes	☐ Yes	☐ No	☐ Affect	☐ Yes	☐ No	
☐ Performing ADLs	☐ Yes	☐ No	☐ Mood	☐ Yes	☐ No	
☐ Impulse control/behavior	☐ Yes	☐ No	☐ Sleep	☐ Yes	☐ No	

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.

Discharge plan

Note changes and barriers to discharge planning in these areas and plan for resolving barriers. If a recent readmission, indicate what is different about the plan from last time.

Housing issues:
Psychiatry:
Therapy and/or counseling:
Medical:
Wraparound services:
Substance use services:
Planned discharge level of care:
Expected discharge date:

Submitted by:		**Phone #:**	