

BEHAVIORAL HEALTH — LEVEL OF CARE REQUEST FORM

For Eating Disorders level of care requests, complete the relevant supplemental section on page 2.

MEMBER NAME:			
DOB:		GENDER:	
HEALTH PLAN:	Health Plan Fax #:	POLICY #:	
Requesting Clinician/Facility:		Phone #:	
Phone #:	Fax #:	NPI:	TIN:
Servicing Clinician/Facility:			
Phone #:	Fax #:	NPI:	TIN:
Currently in an ER: <input type="checkbox"/> Y / <input type="checkbox"/> N		Date and Time of Request:	
Service Date for Request:			
LEVEL OF CARE REQUESTED			
<input type="checkbox"/> Inpatient <input type="checkbox"/> Partial Hospitalization <input type="checkbox"/> Community Stabilization/Treatment (<input type="checkbox"/> ICBAT <input type="checkbox"/> CBAT <input type="checkbox"/> CCS/CSU) <input type="checkbox"/> Residential <input type="checkbox"/> Outpatient Psychotherapy (except 90837/90838) <input type="checkbox"/> 90837/90838 (<input type="checkbox"/> ACT <input type="checkbox"/> CBT <input type="checkbox"/> Cognitive Processing <input type="checkbox"/> DBT <input type="checkbox"/> EMDR <input type="checkbox"/> Exposure <input type="checkbox"/> Functional Family <input type="checkbox"/> PCIT <input type="checkbox"/> IPT <input type="checkbox"/> Other: _____ <input type="checkbox"/> Family Stabilization <input type="checkbox"/> Other: _____			
SERVICE TYPE			
<input type="checkbox"/> Behavioral Health <input type="checkbox"/> BH in General Hospital <input type="checkbox"/> Dual Diagnosis <input type="checkbox"/> Eating Disorder			
CHIEF COMPLAINT/REASON FOR REQUEST/DIAGNOSES			
Chief Complaint/Reason for Request (Frequency, intensity, duration of symptoms) <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> acutely life threatening _____ Are there any functional impairments? <input type="checkbox"/> Y / <input type="checkbox"/> N			
Medications: <input type="checkbox"/> none <input type="checkbox"/> antidepressant <input type="checkbox"/> antianxiety <input type="checkbox"/> antipsychotic <input type="checkbox"/> mood stabilizer <input type="checkbox"/> stimulant <input type="checkbox"/> other			
Primary Psychiatric diagnosis:		ICD/DSM Code:	
Secondary Psychiatric diagnosis:		ICD/DSM Code:	
Substance Use Disorder diagnosis:		ICD/DSM Code:	
Relevant active medical problems <input type="checkbox"/> Y / <input type="checkbox"/> N Medically cleared <input type="checkbox"/> Y / <input type="checkbox"/> N Needs further evaluation/intervention <input type="checkbox"/> Y / <input type="checkbox"/> N			
Relevant Active Medical diagnoses:		ICD Code:	
Prior Admissions <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> Unknown		INPATIENT: # of times _____ most recent _____	
SUBSTANCE USE/DETOX: # of times _____ most recent _____		OTHER: (specify) _____ # of times _____ most recent _____	
MEDICAL/PSYCHOSOCIAL RISKS AND FUNCTIONAL IMPAIRMENTS (select all that apply to the current request):			
1. Suicidal: <input type="checkbox"/> Current Ideation <input type="checkbox"/> Active Plan <input type="checkbox"/> Current Intent <input type="checkbox"/> Access to Lethal Means <input type="checkbox"/> None <input type="checkbox"/> Section 12 <input type="checkbox"/> Current Suicide Attempt <input type="checkbox"/> Prior Suicide Attempt (<1 year) Explain: _____			
2. Homicidal/Violent: <input type="checkbox"/> Current Ideation <input type="checkbox"/> Active Plan <input type="checkbox"/> Current Intent <input type="checkbox"/> Access to Lethal Means <input type="checkbox"/> None <input type="checkbox"/> Current Threat to Specific Person <input type="checkbox"/> Prior Violent Acts (<1 year) Explain: _____			
3. Self-Care/ADLs: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> acutely life-threatening Explain: _____ Highest and Lowest Levels of Functioning (<1 year): _____			
4. Self-Injurious Behavior: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> acutely life-threatening Explain: _____ Agitated/Aggressive Behavior: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> acutely life-threatening Explain: _____			
5. Medication Adherence: <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> Unknown, Other Treatment Adherence <input type="checkbox"/> Y / <input type="checkbox"/> N Explain: _____			
6. Legal Issues, Court/DYS Involvement: <input type="checkbox"/> Y / <input type="checkbox"/> N Explain: _____			
7. Employment Risks: <input type="checkbox"/> employed <input type="checkbox"/> employment at risk <input type="checkbox"/> on/requesting medical leave <input type="checkbox"/> disabled <input type="checkbox"/> unemployed <input type="checkbox"/> Other Explain: _____			
8. Psychosocial/Home environment: <input type="checkbox"/> supportive <input type="checkbox"/> neutral <input type="checkbox"/> directly undermining <input type="checkbox"/> home risk/safety concerns <input type="checkbox"/> homeless <input type="checkbox"/> lives alone <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> separated <input type="checkbox"/> dependents <input type="checkbox"/> Other Explain: _____			
9. Additional Concerns: <input type="checkbox"/> Y / <input type="checkbox"/> N Explain: _____			
10. Outpatient BH/SUD treatment in place? <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> Unknown, Have the outpatient treaters been contacted? <input type="checkbox"/> Y / <input type="checkbox"/> N			

BH Level of Care: Supplemental — for Eating Disorders

Eating Disorders level of care requests (complete the following):

Level of Care:

- | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Inpatient Eating Disorders Specialty Unit (medically unstable)
<input type="checkbox"/> Acute Residential Eating Disorders Unit
<input type="checkbox"/> Partial Hospital Eating Disorders Program (seven days per week) | <input type="checkbox"/> Partial Hospital Eating Disorders Program (weekdays, 9–2 or 9–5)
<input type="checkbox"/> Intensive Outpatient Eating Disorders Program (several days per week, a few hours)
<input type="checkbox"/> Outpatient Eating Disorder Program |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Height:	Weight:	BMI:	% IBW:
Highest weight:	Lowest weight:	Weight change in one month:	

Orthostatic Vitals: sitting BP____/____ PR ____ standing BP____/____ PR ____

Labs: Potassium ____ Sodium ____ Relevant abnormal labs _____
 Abnormal _____
 EKG: Y / N
 Medical Evaluation: Y / N If yes, when _____
 Recent need for IV hydration: Y / N If yes, when _____

Current Symptoms: dizziness fainting palpitations shortness of breath amenorrhea cold intolerance vomiting blood

Current Behaviors: bingeing purging restricting over exercising None

Current Abuse of: laxatives diuretics diet pills ipecac None

Specify other pertinent symptoms, behaviors, or high-risk presentations:

THIS SECTION IS REQUIRED FOR MASSHEALTH AND GIC MEMBERS ONLY

Are psychotropic meds being prescribed? Yes No Unknown *If Yes, prescribed by: MD RN CS/NP PCP

Prescriber: _____

List meds: _____

Have you communicated with the member's prescriber of psychotropic drugs?

Yes No N/A; Member not on medications N/A; Provider is the prescriber

Have you communicated with member's PCP? Yes No Member declined

Have you documented the communication or member declination? Yes No N/A; I did not contact PCP

Have you been in communication with other BH providers for this member?

Yes (please specify): _____ No Member declined N/A; There are no other BH providers

Was a standard instrument used to evaluate treatment progress? Yes No *If Yes, name instrument(s): _____

**This form is intended for fully-insured plans only. Not all carriers require prior authorization for the above services; not all levels of care are available in member benefit plans. Providers should consult the health plan's coverage policies and member benefits.*