Amerigroup
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Medicare Advantage

Behavioral Health Concurrent Review Form

To request electroconvulsive therapy (ECT) services, please submit this form electronically at https://www.availity.com or via fax to 1-877-434-7578.

Date					
Level of care					
☐ Inpatient psych ☐ Inpatient detox ☐ Inpatient chemical dependency ☐ Partial hospital program — low intensity ☐ Partial hospital program — high intensity					
Contact information					
Member name		Member ID or reference number		Member DOB	
Member address		Member phone number			
Patient identifying access code					
Facility contact name and phone number (if changed)		Admitting facility name			
Facility provider number or NPI		Facility unit and phone number (if changed since initial review)			
Diagnoses					

Coverage provided by Amerigroup Inc.

Risk assessment
In the past 24 to 48 hours, has the patient shown suicidal or homicidal thoughts or plans, physical aggression to self or others, or auditory hallucinations? ☐Yes ☐No On close observation, has the member shown drug and/or alcohol withdrawal symptoms or comorbid health concerns? ☐Yes ☐No
If yes, explain below.
Lab results
Medications
List current medications and the dates of any medication changes. Include medications for physical conditions. If medications require prior authorization, indicate how this is being addressed. For medications that are taken on an as-needed basis, indicate when they are administered.

Provide a summary of family therapy including date, time, participants and outcome.
Provide a summary of nursing notes including dates.
Provide a summary of MD notes including dates.
Summarize other treatment plan changes or assessments. Include results of chemical dependency assessment, medical assessments and treatments.

For patients with substance use disorders, please complete the following additional information.

Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (describe or give symptoms)	**Risk rating**
Dimension one — acute intoxication and/or withdrawal potential such as vitals, withdrawal symptoms:	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension two — biomedical conditions and complications:	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension three — emotional, behavioral or cognitive complications:	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension four — readiness to change:	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension five — relapse, continued use or continued problem potential:	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension six — recovery living environment:	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?	
Response to treatment	

Support system			
Include coordination activities with case managers, family, community agencies and others.			

Discharge planning			
Note all changes and barriers to discharge in the areas below and a plan for resolving these barriers. If the discharge is the result of a recent readmission, indicate what has changed in the new plan.			
Housing			
Psychiatry			
Therapy and/or counseling			
Medical			
Wraparound services			
Substance abuse services			
Was a discharge appointment scheduled?	☐Yes ☐No	Date of appointment	
Days requested/ expected length of stay			

Submitted by			
Printed name		Phone number	
Signature			

Protected Health Information (PHI)
These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at 1-866-805-4589.

Providers: You are required to return, destroy or further protect any PHI you receive pertaining to patients that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

☐ By checking this box, I hereby certify that the protected health information (PHI) contained in the correspondence received in error has been destroyed and has not otherwise been retained, utilized, or further disclosed. In the event the PHI must be retained it will further be protected until the time it can be destroyed.