Behavioral Health Initial Review

Please submit this form electronically using our preferred method at **https://www.availity.com**. This can also be submitted via fax to 1-877-434-7578.

Submitter information					
Date					
Contact information					
Level of care					
☐Inpatient psych ☐Inpatient detox	☐ Inpatient chemical dependency	☐ Partial hospital program, low intensity	☐ Partial hospital program, high intensity		
Member information					
Member name		Member ID or reference #		Member DOB	
Member address				Member phone	
Patient identifying access code		For child/adolescent, name of parent/guardian		Primary spoken language	
Facility and provider information					
Name of utilization review (UR) contact		UR phone			
Admission date		UR fax number			
☐ Voluntary ☐ Involuntary If involuntary, date of commitment:					
Admitting facility name		Facility provider # or NPI			
Attending physician (first and last name)		Attending physician phone			
Provider # or NPI		Facility unit		Facility phone	
Discharge planner name		Discharge planner phone			
Diagnoses (psychiatric, chemical dependency and medical)					
Precipitant to admission					
Why is the treatment needed now? Please be as specific as possible.					
Risk assessment					
Include medical necessity reasons for admission.					

Current legal issues

Substance abuse or dependency
Current UA/lab results and use pattern (substances, last use, frequency, duration, sober history, vitals)

For 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?	

Previous treatment
Include provider name, facility name, medications, specific treatment/levels of care and adherence.

Current treatment plan
Standing medications:
As-needed 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 and others. If case is open with another agency, name the agency, phone number 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?
Preliminary discharge plan
For example, patient will return home, go into outpatient care, partial hospital program, etc. Do not leave blank or put TBD.
Days requested or expected length of stay from today:

Submitted by:	Phone:

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☐ 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.