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https://providers.amerigroup.com/DC

Behavioral Health Concurrent Review Form

This form is for inpatient, residential treatment, Partial Hospitalization Program and intensive outpatient.

Please submit via the provider website at https://providers.amerigroup.com/DC or by fax to 1-877-434-7578 on the last authorized day.

Today's date:		
Contact information		
Level of care: Inpatient psychological ☐ Inpatient detox ☐ Inpatient chemical dependency ☐ Psychiatric RTC ☐ Chemical dependency RTC ☐ PHP ☐ IOP ☐		
Member name:	Member ID or reference #:	Member DOB:
Member address:		Member phone #:
Facility contact name and phone # (if changed):		Admitting facility name:
Facility provider # or NPI:	Facility unit and phone # (if changed since initial review):	
DSM-5/ICD-10 diagnoses (document changes only)		
Risk assessment		
In the past 24 to 48 hours, has the member shown suicidal or homicidal thoughts or plans, physical aggression to self or others, command auditory hallucinations on close observation, drug and/or alcohol withdrawal symptoms, or comorbid health concerns?		
If yes, explain:		
Lab results		
Medications: List current medications and any changes with dates. Include medications for physical conditions. If medications require prior authorization, indicate how this is being addressed. Indicate as-needed medications and when actually administered.		
Summary of family therapy (date, time, who participated and outcome):		

Summary of nursing notes:
Summary of M.D. notes:
Other treatment plan changes or assessments (Include results of chemical dependency assessment, medical assessments or treatments. **Please attach summary sheets of LOCUS, CASII or other assessments if applicable.**):

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 1 (acute intoxication and/or withdrawal potential — Include vitals and withdrawal symptoms): _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 2 (biomedical conditions and complications): _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 3 (emotional, behavioral or cognitive complications): _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 4 (readiness to change): _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 5 (relapse, continued use or continued problem potential): _____ _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐
Dimension 6 (recovery living environment): _____ _____	Minimal/none: ☐ Mild: ☐ Moderate: ☐ Significant: ☐ Severe: ☐

Treatment
If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?
Response to treatment:
Involvement in treatment or discharge planning of member, family/guardian(s), outpatient providers or other identified supports:
Discharge planning: Note changes, 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 abuse services:
Was posthospital discharge appointment scheduled? ☐ **Yes** ☐ **No** **Appointment date:**
Days requested or expected length of stay from today:

Submitted by:	**Phone #:**