Amerigroup RealSolutions
Medicare Advantage Plans

Behavioral health initial review
(For inpatient, residential treatment center, partial hospitalization program and intensive outpatient program)

Please fax to 1-877-434-7578 within two hours of admission or prior to admission for non-urgent services.

Today's date:		
Contact information		
Level of care: Inpatient psych: ☐ Inpatient detox: ☐ Inpatient chemical dependency: ☐ Psychiatric RTC: ☐ Chemical dependency RTC: ☐ PHP: ☐ IOP: ☐		
Member name:	Member ID or reference number:	Member date of birth:
Member address:		Member phone number:
Hospital account number:	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 or involuntary?	
Admitting facility name:	Facility provider number or NPI:	
Attending physician first and last names:	Attending physician phone number:	
Provider number or NPI:	Facility unit:	Facility phone number:
Discharge planner name:	Discharge planner phone number:	
Diagnoses (psychiatric, chemical dependency and medical):		

Important Note: You are not permitted to use or disclose Protected Health Information about individuals that you are not currently treating or have enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

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Precipitant to admission Be specific. Why is the treatment needed now?
Risk assessment Include medical necessity reasons for admission.
Current legal issues
Substance abuse or dependence 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 1 (Acute intoxication and/or withdrawal potential. Include vitals, 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: ☐

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Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (Describe or give symptoms)	**Risk Rating**
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: ☐

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 (PRN) medications administered (not ordered):

Other treatment and/or interventions planned (including when family therapy is planned):

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Support system	
(Include coordination activities with case managers, family, community agencies, etc. 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?
Initial discharge plan List name and number of discharge planner and include whether the member can return to current residence.	
Days requested or expected length of stay from today:	
Submitted by:	Phone number: