



Behavioral Health initial review form

(Inpatient [MH or CD], CD Residential Treatment Program, PMIC, Partial hospitalization program [PHP] or Intensive Outpatient Program [IOP])

Please submit via the provider portal at providers.amerigroup.com/ia or fax to 1-877-434-7578.

Today's date:		
Contact information		
Level of care: Inpatient psych: <input type="checkbox"/> Inpatient detox: <input type="checkbox"/> PMIC: <input type="checkbox"/> Chemical dependency Residential Treatment Program: <input type="checkbox"/> PHP: <input type="checkbox"/> IOP: <input type="checkbox"/>		
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 contact:		Utilization review contact phone number: Utilization review fax number:
Admit date:	Level of care:	Voluntary or involuntary? (If involuntary, attach copy of court order (48 hr. hold or 5 day committal))
Facility name:		Facility NPI or Amerigroup Iowa, Inc. provider number:
Attending physician first and last names:		Attending physician phone number:
Provider NPI or Amerigroup provider number:	Facility unit:	Facility phone number:
Discharge planner name:	Discharge planner phone number:	
ICD-10 diagnoses		
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:	
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?

Co-occurring medical/physical illness

Functional impairment/strength (including interpersonal relations, personal hygiene, work/school)

Recovery environment (describe, including support system, level of stress)

Engagement/level of active participation in treatment (past and present)	
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):	
Coordination of care (include coordination activities with case managers, family, community agencies, etc. If case is open with another agency, name the agency, phone and case number.)	
Readmission within last 30 days?	
Yes <input type="checkbox"/> No <input type="checkbox"/> 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)	
Please attach summary sheets of any assessments, if applicable, which may support your request.	
Expected length of stay from today:	
Submitted by:	Phone:

Important Note: You are not permitted to use or disclose Protected Health Information about individuals who you are not currently treating or are not 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.