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

Please fax to 1-877-434-7578 on the last authorized day.

Today's date:		
Contact information		
Level of care: Inpatient psych: ☐ Psychiatric RTC: ☐		
Member name:	Member Amerigroup ID or reference number:	Member date of birth:
Member address:		Member phone number:
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 (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, or command auditory hallucinations? On close observation, has the member shown 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 (PRN) medications actually administered and when.
Summary of family therapy (date, time, who participated, 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):

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 post-hospital discharge appointment scheduled? ☐ Yes ☐ No Appointment date:	
Days requested or expected length of stay from today:	
Submitted by: Print name: Signature:	Phone number: