

Behavioral Health Concurrent Review Form

Please submit this form electronically using our preferred method at <https://providers.amerigroup.com/NJ>. You may also submit via fax to 1-877-434-7578. Please submit on the last authorized day.

Date: _____

Contact information		
Member name:	Member ID or reference number:	Member DOB:
Member address:		Member phone:
Facility contact name and phone (if changed):	Admitting facility name:	
Facility provider number or NPI:	Facility unit and phone number (if changed since initial review):	
Level of care		
<input type="checkbox"/> Inpatient psych	<input type="checkbox"/> Inpatient detox (ASAM 4)	<input type="checkbox"/> SUD — partial care (ASAM 2.5)
<input type="checkbox"/> Partial hospitalization	<input type="checkbox"/> Nonmedical detox (ASAM 3.7WM)	<input type="checkbox"/> SUD — IOP (ASAM 2.1)
<input type="checkbox"/> Partial care	<input type="checkbox"/> Short-term residential (ASAM 3.7)	
<input type="checkbox"/> AMHR	<input type="checkbox"/> Ambulatory withdrawal (ASAM 2WM)	
Diagnoses (document changes only)		
Risk assessment		
In the past 24-48 hours, has the member shown suicidal or homicidal thoughts or plans, physical aggression to self or others, or command auditory hallucinations; on close observation, drug and/or alcohol withdrawal symptoms or comorbid health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, explain: <div style="border: 1px solid black; height: 100px; width: 100%; margin-top: 5px;"></div>		

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

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 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.)

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) <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension 2 (biomedical conditions and complications) <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension 3 (emotional, behavioral or cognitive complications) <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension 4 (readiness to change) <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension 5 (relapse, continued use or continued problem potential) <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension 6 (recovery living environment) <hr/> <hr/> <hr/> <hr/>	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe

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 post-hospital discharge appointment scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Appointment date:	Days requested or expected length of stay from today:
Submitted by:	Phone number: