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Behavioral Health Initial Review Form

(For inpatient, partial hospital, partial care and all substance abuse ASAM levels)

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 within two hours of admission or prior to admission for nonurgent services.
Date: _____

Contact information		
Member name:	Member ID or reference number:	Member DOB:
Member address:		Member phone:
Hospital account number:	For child/adolescent, name of parent/guardian:	Primary language spoken:
Name of utilization review contact:	Utilization review contact phone:	Utilization review fax:

Admit date:	Voluntary or involuntary:	
Admitting facility name:	Facility provider number or NPI:	
Admitting physician name:	Attending physician phone:	
Provider number or NPI:	Facility unit:	Facility phone:
Discharge planner name:	Discharge planner phone:	

Level of care		
☐ Inpatient psych ☐ Partial hospitalization ☐ Partial care ☐ AMHR	☐ Inpatient detox (ASAM 4) ☐ Non-medical detox (ASAM 3.7WM) ☐ Short-term residential (ASAM 3.7)	☐ Ambulatory withdrawal (ASAM 2WM) ☐ SUD — partial care (ASAM 2.5) ☐ SUD — IOP (ASAM 2.1)

Diagnoses (psychiatric, chemical dependency and medical)

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.

Precipitant to admission Please 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)

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?	

Previous treatment (Include provider name, facility name, medications, specific treatment/levels of care and adherence.)	
Current treatment plan	
Standing medications:	
As-needed medications administered (not ordered):	
Other treatment and/or interventions planned (including when family therapy is planned):	
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 the name and number of the discharge planner and include whether the member can return to current residence.	
Days requested or expected length of stay from today: _____	
Submitted by:	Phone: