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Behavioral Health Adult Mental Health Rehab Initial Review Form

Please submit this form electronically using our preferred method at https://providers.amerigroup.com/NJ. This can also be submitted via fax to 1-877-434-7578. Please submit this form before admission.

Date: _____

Contact information		
Member name:	Member ID or reference number:	Member DOB:
Member address:		Member phone:
For child/adolescent, name of parent/guardian:	Primary spoken language:	
Facility/provider submitting clinical review:	Requested AMHR:	
Requested AMHR admit date:	Member's current location:	
Can member return to current location (if applicable)?		
Clinician or doctor who can provide AMHR precertification review (if needed):	Clinician or doctor's phone:	
Person completing form:	Phone of person completing form:	
Diagnosis (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 AMHR level of care needed? Clearly document behaviors occurring in the previous three months.
Barriers to treatment progress (if admitted)

Current legal issues

Substance abuse or dependence Include current urinary analysis/lab results.

Previous treatment Please be specific: Include dates of service, 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:

Support system Include coordination activities with case managers, family, community agencies, etc. If the case is open with another agency, name the agency, phone number and case number.
Social history

Initial discharge plan List the name and phone number of the discharge and provider names, addresses and phone numbers.
Days requested for this review:
Expected length of stay from today:
Submitted by:
Phone number: