

(All substance use disorder services Level 3.1 and higher)

Submit to: Behavioral Health Utilization
Management Fax: 1-855-410-6638
For assistance, please call: 1-877-464-2911

**Please note: Authorization is based on medical necessity. Incomplete or illegible forms will delay processing.
Please provide all pertinent clinical information, including clinical assessment, ASAM, and treatment plans.**

Date:	Date of admission or service start date:	Estimated length of stay:
<input type="checkbox"/> Notification only	<input type="checkbox"/> Precertification	<input type="checkbox"/> Continued stay

REQUESTED SERVICE

<input type="checkbox"/> SUD acute detox in a hospital setting Service or revenue code: Date of discharge:	<input type="checkbox"/> Level 3.7: Medically monitored intensive inpatient Service code with modifier(s):	<input type="checkbox"/> Level 3.7-WM: Medically monitored inpatient withdrawal management Service code with modifier(s):
<input type="checkbox"/> Level 3.5: Clinically managed high-intensity residential Service code with modifier(s):	<input type="checkbox"/> Level 3.3: Clinically managed high-intensity residential (pop spec) Service code with modifier(s):	<input type="checkbox"/> Level 3.2-WM: Clinically managed residential withdrawal management Service code with modifier(s):
<input type="checkbox"/> Level 3.1: Low-intensity residential Service code with modifier(s):		

MEMBER INFORMATION

Name (last, first, MI):		
Date of birth:	Phone number:	Eligibility ID number:
Address:		
Emergency contact:		
Relationship:	Phone number:	
If dependent adult, legal guardian:	Phone number:	

PROVIDER INFORMATION

Facility name:		
Facility address:		
Facility NPI/tax ID:	Facility phone number:	Facility fax number:
UM review contact name:	Attending physician:	NPI/tax ID:

DIAGNOSES

Primary diagnosis:	Secondary diagnosis:	Tertiary diagnosis:
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MEDICATIONS				
Home medications, if known, including dosages and prescriber (e.g., PCP or psychiatrist):				
Name of current treating psychiatrist, if any:				Date last seen:
Medication name	Dosage	Frequency	Date of last change, if applicable	Type of change
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
Additional information, if applicable:				

CURRENT RISK AND LETHALITY		
Suicidal: <input type="checkbox"/> No <input type="checkbox"/> Yes — please answer questions below.		
Active recurrent thoughts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Making threats: <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No
Available means: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		
Command hallucinations: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		
History of suicide attempts: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		
Homicidal thoughts: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		
Active recurrent thoughts: <input type="checkbox"/> Yes <input type="checkbox"/> No	Making threats: <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan: <input type="checkbox"/> Yes <input type="checkbox"/> No
Available means: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		
Command hallucinations: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		
History of homicide attempts: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		
Assault or violence: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		
History of assault or violence: <input type="checkbox"/> No <input type="checkbox"/> Yes — please explain:		

MENTAL STATUS EXAM
(Including appearance, eye contact, speech, motor activity, thought process and content, orientation, mood, affect, and hallucinations)

PRESENTING PROBLEM/CURRENT CLINICAL
Current clinical (SI, HI, psychosis, mood or affect, sleep, appetite, withdrawal symptoms, chronic SUD):
Describe member's functioning:
<input type="checkbox"/> Activities of daily living (ADLs):
<input type="checkbox"/> Social settings:
<input type="checkbox"/> Education and occupation:
<input type="checkbox"/> Current living environment:
<input type="checkbox"/> Indicate the recommendations of the member's assessment or evaluation and treatment plan:

TREATMENT HISTORY AND/OR CURRENT TREATMENT PARTICIPATION
How long has the member experienced mental illness and/or an SUD?
<input type="checkbox"/> Previous treatment — please provide specifics:
<input type="checkbox"/> Current treatment — please provide specifics:
<input type="checkbox"/> No previous or current treatment noted



DIMENSION RATING CURRENT ASAM DIMENSIONS ARE REQUIRED (none, stable, low, moderate, severe)				
Dimension 1: acute intoxication and/ or withdrawal potential Rating:	Substances used (pattern, route, last used):	Toxicology screen completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, results:	History of withdrawal symptoms: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current withdrawal symptoms:
Dimension 2: biomedical conditions and the complications Rating:	Vital signs:	Is the member under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, known medical condition:	History of withdrawal seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any additional pertinent information:
Dimension 3: emotional, behavioral, or cognitive conditions and complications Rating:	Mental health diagnosis:	Cognitive limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current medications and dosages, if not listed on page 2	Current risk factors (SI, HI, and psychotic symptoms):
Dimension 4: readiness to change Rating:	Awareness and commitment to change:	Internal or external motivation:	Stage of change, if known:	Legal problems and probation officer:
Dimension 5: relapse, continued use, or continued problem potential Rating:	Relapse prevention skills:	Current assessed relapse risk level: <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	Longest period of sobriety:	Any additional pertinent information:
Dimension 6: recovery and living environment Rating:	Living situation:	Sober support system: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, whom:	Attendance at support group: <input type="checkbox"/> Yes <input type="checkbox"/> No	Issues that impede recovery:



DISCHARGE PLANNING

Discharge planner name:

Phone number: Fax number:

Place of residence upon discharge:

Address:

Treatment setting and services upon discharge:

Provider of services, if known:

Has a post-discharge seven-day follow-up aftercare appointment been scheduled? Yes (complete below)

Provider name: Date and time of appointment:

No — please explain:

Identify collaboration needs. Please indicate if collaboration is needed with any of the below, including contact name and phone number:

- Child or adult protective agency:
- Group home:
- Nursing or nursing home facility:
- Residential program:
- Jail, prison, or court system:
- LTSS or waiver programs:
- Other:

Provider Signature:

Date: