Clinical Services

Utilization Management

Fax to: 1-877-650-6112

Requested Service (check all that applies)**:**

❑Psychiatric ❑Substance Abuse

❑ Inpatient ❑ Inpatient Detox ❑ Inpatient Rehab
❑ Residential Treatment Facility ❑ Partial Hospitalization Program
❑ Intensive Outpatient Program

❑ Initial Request	❑ Concurrent Request	**Case #:**	**Start of Care Date:**

Section 1 Member Information

Member Name: (Last, First, MI)	Date of Birth:	Member ID:
Address: (No., Street, City, State, Zip)		Phone Number: ( )

Section 2 Contact Information

Requesting Provider/Facility: NPI: Address: (No., Street, City, State, Zip)	Contact Numbers: (P): (F): Contact Name:
Servicing Provider/Facility: (if different from above) NPI: Address: (No., Street, City, State, Zip)	Contact Numbers: (P): (F): Contact Name:
Attending Physician Name:	

Section 3 Clinical Information

Admission Summary/Presenting Symptoms (initial request only):

Current Symptoms/Clinical Update/Current Request:

Current Diagnoses:

Section 4 Psychiatric Symptoms

a. Suicidal/ Homicidal:	❑ Ideation	❑ Gesture	❑ Attempt	❑ Self-Harm/Aggression	
b. Psychosis:	❑ Hallucinations	❑ Delusions	❑ Loose Associations	❑ Dissociation	❑ Inappropriate Affect
c. Mood:	❑ Depressed Mood ❑ Weight Loss / Gain	❑ Hypomania ❑ Mania ❑ Loss of Motivation/Pleasure		❑ Sleep Disturbance ❑ Concentration ❑ Worthlessness / Guilt	
d. Anxiety:	❑ Panic Attacks ❑ Hyper Vigilance	❑ Chronic Worrying ❑ Obsessive Thoughts ❑ Phobia		❑ Compulsive Behaviors	
e. Cognitive:	❑ Dementia	❑ Delirium	❑ Distractible		
f. Somatic:	❑ G.I.	❑ Pain	❑ Conversion /Pseudoneurologic		
g. Development Disorders:		❑ Autism Spectrum Disorder ❑ Intellectual Disability ❑ Other Learning Problems: _____			
h. Disruptive Behavior:		❑ Oppositional / Conduct	❑ Impulsivity	❑ Hyperactivity	

Section 5 Medications

❑ **Initial Request (admission medications):**

❑ **Concurrent Request (current medications including date of medication adjustments):**

PRNs used in the last 24 hours?

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Section 6	**Substance Abuse**	
Description of past/present drug/alcohol usage (include drug(s) used, age of first use, duration of use, last use):		
VITAL SIGNS: (for detox only)		
Date/Time:	Date/Time:	Date/Time:
BP: /	BP: /	BP: /
Pulse:	Pulse:	Pulse:
Respirations:	Respirations:	Respirations:
Temperature:	Temperature:	Temperature:
COWS/CIWA:	COWS/CIWA:	COWS/CIWA:
Please include description of applicable ASAM Dimensions:		

Section 7	**Other Relevant Clinical Information**
Please include description of other relevant clinical information (include chronic medical conditions, past psychiatric history and related inpatient/outpatient treatment, member support systems, housing and home environment):	

Section 8	**Disposition Information**
Please include disposition plan for member upon discharge:	

Submission Instructions:

Please print all information.

IMPORTANT! THIS REQUEST FOR AUTHORIZATION REVIEW CANNOT BE PROCESSED WITHOUT SUPPORTING CLINICAL DOCUMENTATION AND/OR INFORMATION – NO EXCEPTIONS.

Requests missing clinical information will be returned to the requesting provider, delaying the review process.

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