BH Inpatient Request

BH Utilization Management

Fax to 1-833-581-1866

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

❑Psychiatric ❑Substance Abuse

❑ Inpatient ❑ Inpatient Detox ❑ Inpatient SUD Rehab

❑ Residential Treatment Facility

❑ Initial Request	❑ Clinical Update		**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) Contracted with local Blues Plan?			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 /Pseudo neurologic		
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):**	

- [ ] **Clinical update- (current medications including date of medication adjustments):**

PRNs used in the last 24 hours?

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:	

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.

Fax to: Behavioral Health, Utilization Management, 1-833-581-1866