



SUBMIT TO:
 Utilization Management Department
 PHONE 1-866-534-5976 FAX 1-866-535-6974

Behavioral Health (BH) Concurrent Review Form

Reviewed Clinical History (Previous Authorizations, Impact Pro, etc.): Yes No

BILLING PROVIDER

Facility: _____ UR/Phone #: _____ LOC: _____

Fax: _____ NPI #: _____

Voluntary or Involuntary: _____ Admit Date: _____

DIAGNOSTIC AND TREATMENT INFORMATION

Dx: _____

Current Medications/Changes (Dates): _____

PRN's (Date, Time): _____

Compliance: _____

BAL/UDS: _____

Health Updates: _____

Precautions: _____

Tx Plan Progress: _____

Physician Notes: (Include Date/MSE):

Staff Notes:

Therapy Notes:

Barriers to Discharge: _____

Discharge Criteria/Plan: _____

Discharge Planner: _____ Phone #: _____

ELOS: _____

Things to Address Next Review: _____
