



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

Behavioral Health Initial Review Form

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

BILLING PROVIDER

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

DIAGNOSTIC AND TREATMENT INFORMATION

Admit Dx: _____ Admit Date: _____

Attending Physician: _____ Phone #: _____

Other Insurance: _____

Guardian: _____

(If FC, CPS Case Worker) Name: _____ Phone #: _____

Voluntary or Involuntary: _____

Admit Symptoms: _____

MSE: _____

Psych Hx, (Including Medications, IP Stays, and OP Providers): _____

Trauma/Abuse History: _____

Family Mental Health Hx: _____

Hx of Suicide Attempts (Date, Means): _____

Meds at Admission/Compliance: _____

Any Changes Since Admit: _____

Current Compliance: _____

PRN's (Date, Time): _____

SI/HI (Intent/Plan): _____

Psychosis (Type/Intensity): _____

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PHYSICAL HEALTH INFORMATION

PhysicalHealthHx:	BMI	Allergies	Current Diagnoses			
<hr/> <hr/> <hr/>						
Ht/Wt: _____						
Substance Hx:	Amount	Frequency	First Use	Last Use	Length of Use	Method
<hr/> <hr/> <hr/>						
COWS/CIWA Score If Available: _____ At Admission: _____ Current: _____						
Vitals (For IP Detox): _____						
UDS/BAL (Labs): _____						

SOCIAL FACTORS

Social Factors Impacting Need for IP:	Education	Employment	Legal
<hr/> <hr/> <hr/>			
Support System:	Name	Relationship	Participation In IP treatment
<hr/> <hr/> <hr/>			
Precautions: _____			
<hr/>			
Admitting Treatment Plan/Any Progress: _____			
<hr/>			
ELOS: _____ At Admission: _____ Current: _____			
D/C Criteria/Plan:	7 day F/U Dates	Times	Contact info
<hr/> <hr/> <hr/>			
Placement Issues (FC): _____			
<hr/>			

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Barriers to Successful Discharge: _____

Hospital DC Planner: _____ Phone #: _____

Things to Address on Next Review: _____

LCD: _____

Sent Task/Referral to ICM & Set Task for CCR: _____



FOR PRTF LOC:

Therapeutic Leave Days (TLDs) (overnights) may be requested for this level of care to support the member's treatment plan goals and successful transition into the community for a maximum total of 5 per treatment episode. The member's treatment needs and safety remain the primary focus, therefore safety plans need to be in place.

Are you requesting any TLDs for the next review period?

How many/dates/where will they go/& goals for TLDs?