

Behavioral Health Initial Review

Please submit this form electronically using our preferred method at <https://www.availity.com>. This can also be submitted via fax to 1-844-430-1702.

Submitter information					
Date					
Contact information					
Level of care					
<input type="checkbox"/> Inpatient psych	<input type="checkbox"/> Inpatient chemical dependency	<input type="checkbox"/> Partial hospital program, low intensity	<input type="checkbox"/> Partial hospital program, high intensity		
<input type="checkbox"/> Inpatient detox					
Member information					
Member name		Member ID or reference #		Member DOB	
Member address				Member phone	
Patient identifying access code		For child/adolescent, name of parent/guardian		Primary spoken language	
Facility and provider information					
Name of utilization review (UR) contact		UR phone			
Admission date		UR fax number			
<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary If involuntary, date of commitment:					
Admitting facility name		Facility provider # or NPI			
Attending physician (first and last name)		Attending physician phone			
Provider # or NPI		Facility unit		Facility phone	
Discharge planner name		Discharge planner phone			
Diagnoses (psychiatric, chemical dependency and medical)					
Precipitant to admission					
Why is the treatment needed now? Please be as specific as possible.					
Risk assessment					
Include medical necessity reasons for admission.					

* Availity is an independent company providing administrative services on behalf of Empire BlueCross BlueShield.

Current legal issues
Substance abuse or dependency
Current UA/lab results and use pattern (substances, last use, frequency, duration, sober history, vitals)

For substance use disorders, please complete the following additional information:

Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (describe or give symptoms)	Risk rating
Dimension one — acute intoxication and/or withdrawal potential such as vitals, withdrawal symptoms:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension two — biomedical conditions and complications:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension three — emotional, behavioral or cognitive complications:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension four — readiness to change:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension five — relapse, continued use or continued problem potential:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
Dimension six — recovery living environment:	<input type="checkbox"/> Minimal/none <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Significant <input type="checkbox"/> Severe
If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?	
Previous treatment	
Include provider name, facility name, medications, specific treatment/levels of care and adherence.	
Current treatment plan	
Standing medications:	

As-needed medication administered (not ordered):
Other treatment and/or interventions planned (including when family therapy is planned):

Support system	
Include coordination activities with case managers, family, community agencies and others. If case is open with another agency, name the agency, phone number and case number.	
Readmission within last 30 days	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, and readmission was to the discharging facility, what part of the discharge plan did not work and why?	
Preliminary discharge plan	
For example, patient will return home, go into outpatient care, partial hospital program, etc. Do not leave blank or put TBD.	
Days requested or expected length of stay from today:	
Submitted by:	
Phone:	

Protected Health Information (PHI)
These documents contain PHI. Federal and state laws prohibit inappropriate use of PHI. If you are not the intended recipient or the person responsible for delivering these documents, you must properly dispose of them. If you need instructions, please call us at **1-844-648-9540**.

Providers: You are required to return, destroy or further protect any PHI you receive pertaining to patients that you are not currently treating. You are required to immediately destroy any such PHI, or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

By checking this box, I hereby certify that the protected health information (PHI) contained in the correspondence received in error has been destroyed and has not otherwise been retained, utilized, or further disclosed. In the event the PHI must be retained it will further be protected until the time it can be destroyed.