

# BEHAVIORAL HEALTH — LEVEL OF CARE REQUEST FORM

*(For initial requests – MA providers only)*

*For Eating Disorders level of care requests, complete the relevant supplemental section on page 2.*

MEMBER NAME:	
DOB:	GENDER:
INSURER:	POLICY #:
Requesting Clinician/Facility:	
Phone #:	NPI / TIN#:
Servicing Clinician/Facility:	
Phone #:	NPI / TIN#:
Currently in an ER: <input type="checkbox"/> Y / <input type="checkbox"/> N	Date and Time of Request:
Service Date for Request:	
<b>LEVEL OF CARE REQUESTED</b>	
<input type="checkbox"/> Inpatient <input type="checkbox"/> Partial Hospitalization <input type="checkbox"/> Community Stabilization/Treatment ( <input type="checkbox"/> ICBAT <input type="checkbox"/> CBAT <input type="checkbox"/> CCS/CSU) <input type="checkbox"/> Residential <input type="checkbox"/> Outpatient Psychotherapy (except 90837/90838) <input type="checkbox"/> 90837/90838 ( <input type="checkbox"/> ACT <input type="checkbox"/> CBT <input type="checkbox"/> Cognitive Processing <input type="checkbox"/> DBT <input type="checkbox"/> EMDR <input type="checkbox"/> Exposure <input type="checkbox"/> Functional Family <input type="checkbox"/> PCIT <input type="checkbox"/> IPT <input type="checkbox"/> Other: _____ <input type="checkbox"/> Family Stabilization <input type="checkbox"/> Other: _____	
<b>SERVICE TYPE</b>	
<input type="checkbox"/> Behavioral Health <input type="checkbox"/> BH in General Hospital <input type="checkbox"/> Dual Diagnosis <input type="checkbox"/> Eating Disorder	
<b>CHIEF COMPLAINT/REASON FOR REQUEST/DIAGNOSES</b>	
<b>Chief Complaint/Reason for Request</b> (Frequency, intensity, duration of symptoms) <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> acutely life threatening _____ Are there any functional impairments? <input type="checkbox"/> Y / <input type="checkbox"/> N	
Medications: <input type="checkbox"/> none <input type="checkbox"/> antidepressant <input type="checkbox"/> antianxiety <input type="checkbox"/> antipsychotic <input type="checkbox"/> mood stabilizer <input type="checkbox"/> stimulant <input type="checkbox"/> other	
<b>Primary Psychiatric diagnosis:</b>	ICD/DSM Code:
Secondary Psychiatric diagnosis:	ICD/DSM Code:
<b>Substance Use Disorder diagnosis:</b>	ICD/DSM Code:
Relevant active medical problems <input type="checkbox"/> Y / <input type="checkbox"/> N   Medically cleared <input type="checkbox"/> Y / <input type="checkbox"/> N   Needs further evaluation/intervention <input type="checkbox"/> Y / <input type="checkbox"/> N	
<b>Relevant Active Medical diagnoses:</b>	ICD Code:
Prior Admissions <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> Unknown	INPATIENT: # of times ____ most recent _____
SUBSTANCE USE/DETOX: # of times ____ most recent _____	OTHER: (specify) _____ # of times ____ most recent _____
<b>MEDICAL/PSYCHOSOCIAL RISKS AND FUNCTIONAL IMPAIRMENTS (select all that apply to the current request):</b>	
1. Suicidal: <input type="checkbox"/> Current Ideation <input type="checkbox"/> Active Plan <input type="checkbox"/> Current Intent <input type="checkbox"/> Access to Lethal Means <input type="checkbox"/> None <input type="checkbox"/> Section 12 <input type="checkbox"/> Current Suicide Attempt <input type="checkbox"/> Prior Suicide Attempt (<1 year) Explain: _____	
2. Homicidal/Violent: <input type="checkbox"/> Current Ideation <input type="checkbox"/> Active Plan <input type="checkbox"/> Current Intent <input type="checkbox"/> Access to Lethal Means <input type="checkbox"/> None <input type="checkbox"/> Current Threat to Specific Person <input type="checkbox"/> Prior Violent Acts (<1 year) Explain: _____	
3. Self-Care/ADLs: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> acutely life-threatening Explain: _____ Highest and Lowest Levels of Functioning (<1 year): _____	
4. Self-Injurious Behavior: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> acutely life-threatening Explain: _____ Agitated/Aggressive Behavior: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> acutely life-threatening Explain: _____	
5. Medication Adherence: <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> Unknown, Other Treatment Adherence <input type="checkbox"/> Y / <input type="checkbox"/> N Explain: _____	
6. Legal Issues, Court/DYS Involvement: <input type="checkbox"/> Y / <input type="checkbox"/> N Explain: _____	
7. Employment Risks: <input type="checkbox"/> employed <input type="checkbox"/> employment at risk <input type="checkbox"/> on/requesting medical leave <input type="checkbox"/> disabled <input type="checkbox"/> unemployed <input type="checkbox"/> Other Explain: _____	
8. Psychosocial/Home environment: <input type="checkbox"/> supportive <input type="checkbox"/> neutral <input type="checkbox"/> directly undermining <input type="checkbox"/> home risk/safety concerns <input type="checkbox"/> homeless <input type="checkbox"/> lives alone <input type="checkbox"/> married <input type="checkbox"/> single <input type="checkbox"/> divorced <input type="checkbox"/> separated <input type="checkbox"/> dependents <input type="checkbox"/> Other Explain: _____	
9. Additional Concerns: <input type="checkbox"/> Y / <input type="checkbox"/> N Explain: _____	
10. Outpatient BH/SUD treatment in place? <input type="checkbox"/> Y / <input type="checkbox"/> N / <input type="checkbox"/> Unknown, Have the outpatient treaters been contacted? <input type="checkbox"/> Y / <input type="checkbox"/> N	

## BH Level of Care: Supplemental — for Eating Disorders

**Eating Disorders level of care requests (complete the following):**

Level of Care:

- |   |   |
|---|---|
| <input type="checkbox"/> Inpatient Eating Disorders Specialty Unit (medically unstable)<br><input type="checkbox"/> Acute Residential Eating Disorders Unit<br><input type="checkbox"/> Partial Hospital Eating Disorders Program (seven days per week) | <input type="checkbox"/> Partial Hospital Eating Disorders Program (weekdays, 9–2 or 9–5)<br><input type="checkbox"/> Intensive Outpatient Eating Disorders Program (several days per week, a few hours)<br><input type="checkbox"/> Outpatient Eating Disorder Program |
|---|---|

Height:	Weight:	BMI:	% IBW:
Highest weight:	Lowest weight:	Weight change in one month:	

**Orthostatic Vitals:** sitting BP \_\_\_/\_\_\_ PR \_\_\_ standing BP \_\_\_/\_\_\_ PR \_\_\_

**Labs:** Potassium Sodium Relevant abnormal labs \_\_\_\_\_  
 Abnormal \_\_\_\_\_  
 EKG:  Y /  N  
 Medical Evaluation:  Y /  N If yes, when \_\_\_\_\_  
 Recent need for IV hydration:  Y /  N If yes, when \_\_\_\_\_

Current Symptoms:  dizziness  fainting  palpitations  shortness of breath  amenorrhea  cold intolerance  vomiting blood

Current Behaviors:  bingeing  purging  restricting  over exercising  None

Current Abuse of:  laxatives  diuretics  diet pills  ipecac  None

Specify other pertinent symptoms, behaviors, or high-risk presentations:

*\* This form is intended for fully-insured plans only. Not all carriers require prior authorization for the above services; not all levels of care are available in member benefit plans. Providers should consult the health plan's coverage policies and member benefits.*