

## Mental Health Inpatient Request Form

**Please check line of business for this form:**

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> BlueAdvantage (PPO) <sup>SM</sup> | <input type="checkbox"/> BlueCare Plus (HMO SNP) <sup>SM</sup> | <input type="checkbox"/> CoverKids |
| <input type="checkbox"/> BlueCare <sup>SM</sup>            | <input type="checkbox"/> TennCare <i>Select</i>                |                                    |

**Level of care requesting: (Please check the appropriate level of care.)**

- Inpatient psychiatric acute hospitalization
- BH inpatient detox
- Substance abuse residential treatment
- Sub-acute hospitalization

**Member number:** \_\_\_\_\_

Member name: \_\_\_\_\_

Member date of birth: \_\_\_\_\_

Member contact number: \_\_\_\_\_

**Date request sent:** \_\_\_\_\_

Initial:  Yes  No

Concurrent:  Yes  No

If concurrent, please list auth number and fill out remainder of this section and then skip to concurrent review and treatment/discharge planning section towards bottom of form.

Auth number: \_\_\_\_\_

**Provider name:** \_\_\_\_\_

Provider phone: \_\_\_\_\_

Provider fax: \_\_\_\_\_

**Place of service: Inpatient psychiatric facility**

**Requesting clinician:** \_\_\_\_\_

Clinician provider ID #: \_\_\_\_\_

Clinician NPI #: \_\_\_\_\_

Clinician address: \_\_\_\_\_

**Treating clinician:** \_\_\_\_\_

Clinician provider ID #: \_\_\_\_\_

Clinician NPI #: \_\_\_\_\_

Clinician address: \_\_\_\_\_

**Requested facility:** \_\_\_\_\_

Facility provider ID #: \_\_\_\_\_

Facility NPI #: \_\_\_\_\_

Facility address: \_\_\_\_\_

**Psychiatric ICD-10 diagnosis codes:**

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

**Medical ICD-10 diagnosis codes:**

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

**Requested start date of service:** \_\_\_\_\_

**Units or number of days requesting:** \_\_\_\_\_

**Clinical Information Section**

Date when member initiated request for this service: \_\_\_\_\_

(For initial review. Please see other applicable sections below and fill out all that apply.)

Voluntary or  Involuntary admission?

If involuntary...

	<b>Clinician name/MD name</b>	<b>Date</b>	<b>Time of signature</b>
<b>CONX1:</b>			
<b>CONX2:</b>			

Describe in detail the patient's current condition to include... (thorough mental status, behavioral symptoms).



Medication adherence? Barriers to adherence?

Urinary Drug Screen (UDS) and/or Blood Alcohol (BAL) results:

**Fill out this section only if patient is under the age of 18.**

Who has custody of member? \_\_\_\_\_

Is there any current CPS/DCS involvement?  Yes  No

Do any current symptoms/behaviors occur in school setting?  Yes  No

Is the school involved in current treatment plan?  Yes  No

Is the member involved with special education?  Yes  No

**Fill out this section only if patient has substance abuse issues.**

Note above-referenced UDS and BAL.

Drugs of choice	Amount of use	Frequency of use	Age of first use	Date of last use	Method of administration

Longest period of sobriety including dates: \_\_\_\_\_

Vital Signs:

- Blood pressure: \_\_\_\_\_
- Heart rate: \_\_\_\_\_
- Temperature: \_\_\_\_\_

Is there history of seizures, DT's (delirium tremens) or blackouts?  Yes  No

Is the member pregnant?  Yes  No

If yes, specify duration of pregnancy: \_\_\_\_\_

Current withdrawal symptoms: \_\_\_\_\_

Psychological and/or legal consequences of substance use: \_\_\_\_\_

Substance abuse treatment history including dates: \_\_\_\_\_

Support system involvement: \_\_\_\_\_

Member's triggers: \_\_\_\_\_

**Fill out this section only if patient has eating disorder issues.**

Member height: \_\_\_\_\_

Member weight: \_\_\_\_\_

% Ideal body weight (IBW): \_\_\_\_\_

Current BMI: \_\_\_\_\_

Orthostatic blood pressure: \_\_\_\_\_

Standing: \_\_\_\_\_

Sitting: \_\_\_\_\_

Pulse rate: \_\_\_\_\_

EKG, electrolytes, and other lab information: \_\_\_\_\_

Goal weight/BMI: \_\_\_\_\_

Last known episode of bingeing/purging/withholding: \_\_\_\_\_

Triggers for bingeing/purging/withholding: \_\_\_\_\_

Precipitant(s): \_\_\_\_\_

**Fill out this section only if patient needs sexual offender related services.**

Presenting problem: \_\_\_\_\_

What is current involvement with legal system and/or DCS? \_\_\_\_\_

When was the last time these behaviors occurred? \_\_\_\_\_

In what setting do these behaviors occur?

Is the school setting involved in current treatment plan?  Yes  No

Has a psychosexual assessment been completed prior to this request?  Yes  No

(If yes, please attach said assessment.)

### Fill out this section for concurrent review only.

What progress has been made since the last review in regards to symptoms, behaviors, diagnosis, etc?

Current suicidal/homicidal ideations or psychosis present:

Medication changes:

If no progress, how will the treatment plan be changed?

Family involvement (phone, education, family sessions, visitations), please list details:

### Treatment and Discharge Planning Section

What are the individualized attainable treatment plan goals and objectives for this level of care?

Are there any limitations for family participation in treatment (transportation, non-compliance, legal, etc.)?  Yes  No  
(If yes, please provide details.)

Discharge plan:

Anticipated barriers to discharge:

**Primary care physician name and efforts to coordinate care:**

**Signature of ordering clinician with credentials (required to process):**

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Date of signature: \_\_\_\_\_

**Fax pre-certification numbers:**

BlueAdvantage: 1-888-535-5243  
BlueCare Plus: 1-866-325-6698  
Bluecare/TennCare*Select*: 1-800-292-5311  
CoverKids: 1-800-851-2491

**Customer service numbers:**

BlueAdvantage: 1-800-841-7434  
BlueCare Plus: 1-800-299-1407  
BlueCare: 1-800-468-9736  
TennCare*Select*: 1-800-276-1978  
CoverKids: 1-800-924-7141



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