of Tennessee

Mental Health Inpatient Request Form

Please check line of business for this form:

- ☐ BlueAdvantage (PPO)℠
- ☐ BlueCare℠
- ☐ BlueCare Plus Tennessee
- ☐ CoverKids
- ☐ TennCare*Select*

☐ Check here if this member has a FIDE plan.

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…

	Clinician name/MD name	Date	Time of signature
CONX1:			
CONX2:			

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

Suicidal ideation? (plans/means/intent)

Homicidal ideation? (plans/means/intent)

Psychosis? ☐ Yes ☐ No

Other symptoms/concerns:
Please provide specific details of psychotic symptoms.

Is there duty to warn? ☐ Yes ☐ No
If yes, please provide details.

Describe any history of attempts with specific dates (suicidal attempts, homicidal attempts or overall aggression towards others and/or property).

Precipitant:

Treatment history with specific dates:

Describe member's baseline:

Why can the member not be treated in a lower level of care at this time?

Medications	**Dose**	**Frequency**	**Dates**	**Outcome**

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." then add a text box for this information. _____

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 binging/purging/witholding:_____

Triggers for binging/purging/witholding:_____

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):

Date of signature:_____

Fax pre-certification numbers:

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

Provider service numbers:

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

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Behavioral Health Mental Health Inpatient Fax Form