

Behavioral Health Initial Review Form for Inpatient and Partial Hospital Programs

Instead of faxing this form, submit your request electronically using our preferred method at <https://www.availity.com>. * If you use this form, fax it to **1-844-432-6027**.

Today's date:	
Contact information	
Level of care:	
<input type="checkbox"/> Inpatient psychiatric <input type="checkbox"/> Psychiatric RTC <input type="checkbox"/> IOP mental health <input type="checkbox"/> Inpatient detox	<input type="checkbox"/> PHP mental health <input type="checkbox"/> PHP substance use <input type="checkbox"/> Inpatient substance use rehab <input type="checkbox"/> IOP substance abuse
<input type="checkbox"/> Substance use RTC (ASAM level, if appropriate:)	
Member name:	
Member ID or reference #:	Member DOB:
Member address:	
Member phone:	
Facility account #:	
For child/adolescent, name of parent/guardian:	
Primary spoken language:	
Name of utilization review (UR) contact:	
UR contact phone number:	UR contact fax number:
Admit date:	
<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:

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

<https://providers.healthybluelo.com>

Healthy Blue is the trade name of Community Care Health Plan of Louisiana, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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Discharge planner name:
Discharge planner phone:
Diagnosis (psychiatric, chemical dependency and medical)
Precipitant to admission (Be specific. Why is the treatment needed now?)
Risk of harm to self
If present, describe:
If prior attempt, date and description:
Risk rating (Select all that apply.) <input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior attempt
Risk of harm to others
If present, describe:
If prior attempt, date and description:
Risk rating (Select all that apply.): <input type="checkbox"/> Not present <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Prior attempt
Psychosis
Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed): <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A
If present, describe:
Symptoms (Select all that apply.): <input type="checkbox"/> Auditory/visual hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Delusions <input type="checkbox"/> Command hallucinations

Dimension 3 (emotional, behavioral or cognitive complications)	<ul style="list-style-type: none"> <input type="checkbox"/> Minimal/none — none or insignificant psychiatric or behavioral symptoms <input type="checkbox"/> Mild — psychiatric or behavioral symptoms have minimal impact on treatment <input type="checkbox"/> Moderate — impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADLs <input type="checkbox"/> Significant — suicidal/homicidal ideations, behavioral or cognitive problems or psychotic symptoms require 24-hour monitoring <input type="checkbox"/> Severe — active suicidal/homicidal ideations and plans, acute psychosis, severe emotional lability or delusions; unable to attend to ADLs; psychiatric and/or behavioral symptoms require 24-hour medical management
Dimension 4 (readiness to change)	<ul style="list-style-type: none"> <input type="checkbox"/> Maintenance — engaged in treatment <input type="checkbox"/> Action — committed to treatment and modifying behavior and surroundings <input type="checkbox"/> Preparation — planning to take action and is making adjustments to change behavior; has not resolved ambivalence <input type="checkbox"/> Contemplative — ambivalent; acknowledges having a problem and beginning to think about it; has indefinite plan to change <input type="checkbox"/> Precontemplative — in treatment due to external pressure; resistant to change
Dimension 5 (relapse, continued use or continued problem potential)	<ul style="list-style-type: none"> <input type="checkbox"/> Minimal/none — little likelihood of relapse <input type="checkbox"/> Mild — recognizes triggers; uses coping skills <input type="checkbox"/> Moderate — aware of potential triggers for MH/SA issues but requires close monitoring <input type="checkbox"/> Significant — not aware of potential triggers for MH/SA issues; continues to use/relapse despite treatment <input type="checkbox"/> Severe — unable to control use without 24-hour monitoring; unable to recognize potential triggers for MH/SA despite consequences
Dimension 6 (recovery living environment)	<ul style="list-style-type: none"> <input type="checkbox"/> Minimal/none — supportive environment <input type="checkbox"/> Mild — environmental support adequate but inconsistent <input type="checkbox"/> Moderate — moderately supportive environment for MH/SA issues <input type="checkbox"/> Significant — lack of support in environment or environment supports substance use <input type="checkbox"/> Severe — environment does not support recovery or mental health efforts; resides with an emotionally/physically abusive individual or active user; coping skills and recovery require a 24-hour setting
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 medications 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 so on. If case is open with another agency, name the agency, phone number and case number.)
Results of depression screening
Readmission within the 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?
Initial discharge plan (List name and number of discharge planner and include whether the member can return to current residence.)
Planned discharge level of care:
Describe any barriers to discharge:
Expected discharge date:

Submitted by:
Phone: