Behavioral Health Care Management

Initial Mental Health Treatment Request

COMPLETE ALL SECTIONS (A-K) See Accompanying Instructions on Page 3 and 4

2650 Novation Parkway
Madison, WI 53713
Phone (800) 683-2300
(608) 640-4450
Fax (608) 471-4391

A: MEMBER INFORMATION	
Name:	Date of Birth:
Member Number:	

B: REFERRAL SOURCE / REQUESTING CLINICIAN		
Provider Name:	Phone:	Fax:
Facility/Clinic Name:	Last Date Seen by Referring Provider:	

C: REQUESTED TREATMENT PROVIDER INFORMATION		
Facility Name:	Provider Name:	
Facility Address:		
Contact Name:	Phone:	Fax:

D: TYPE OF SERVICE BEING REQUESTED

☐Inpatient ☐Residential ☐PHP ☐IOP ☐In-Home ☐Outpatient ☐Other *(specify):*

☐TMS **(STOP - Complete Separate TMS Request Form)**

E: SERVICE INFORMATION ☐Mental Health ☐Dual ☐Eating Disorder **(ADDITIONAL EATING DISORDER FORM MUST BE COMPLETED)**	
Number of Visits/Days Requested:	Begin/End Date of Requested Service:___/___/___ to ___/___/___ (mm dd yy mm dd yy)

F: DSM-5/ICD-10 CODES AND DESCRIPTION

Code:	***Description:***

G: BRIEF DESCRIPTION & REASON FOR TREATMENT REQUEST *(be specific & provide examples – use additional pages if needed)*

H: CURRENT RISK

Suicidal: ☐None ☐Current Ideation ☐Active Plan ☐Current Intent ☐Access to Lethal Means ☐Current Suicide Attempt ☐Prior Suicide Attempt **Explain any checked boxes:**_____

_____

Homicidal/Violent: ☐None ☐Current Ideation ☐Active Plan ☐Current Intent ☐Access to Lethal Means ☐Current Threat to Others ☐Prior Acts of Violence **Explain any checked boxes:**_____

_____

Self-Injurious Behavior: ☐None ☐Thoughts ☐Actions Describe:_____

Date of Last Occurrence:_____

Was Medical Attention Required?: ☐Yes ☐No

I: FUNCTIONAL IMPAIRMENTS *Related to areas of social, occupational, scholastic and/or other role functioning*

Self-Care/ADLs/IADLs: ☐unable to structure day time hours ☐poor hygiene ☐medication nonadherence
☐unable to perform key life tasks (chores, meal prep, etc) ☐unable to follow instructions/negotiate needs
☐ unable/difficulty caring for dependents **Specific Examples and Time Frames of Problem Areas**:_____
_____

Current School/ Work Status: ☐frequent absences ☐suspended/on leave ☐expelled/terminated
☐unable to meet obligations/decreased productivity **Explain any checked boxes:**_____
_____

Psychosocial/Home Environment: ☐ supportive ☐ directly undermining ☐ home risk/safety concerns ☐ homelessness ☐ lives alone
☐ increasing isolation/isolative ☐ impaired family/peer relationships **Explain any checked boxes**:
_____

Additional Concerns:_____
_____

J: PRIMARY SYMPTOMS AND CORRESPONDING EXAMPLE

Psychosis	☐ Hallucinations ☐Command Hallucinations ☐ Delusions ☐Loose Association ☐Dissociation ☐Inappropriate Affect ☐Paranoia ☐Decreasing Reality Orientation ☐Disorganized Behavior ☐Bizarre Behaviors Examples: _____ _____
Mood	☐Depression ☐Hypomania ☐Mania ☐Concentration ☐ Weight Loss/Gain ☐Isolating ☐Sleep Disturbances ☐Worthlessness/Guilt ☐Loss of Motivation/Pleasure ☐Hopelessness Examples: _____ _____
Anxiety *OCD* *PTSD*	☐Panic Attacks ☐Chronic Worrying ☐Obsessive Thoughts ☐ Compulsive Behaviors ☐Hypervigilance ☐Phobia ☐Flashbacks ☐PTSD-Associated Symptoms (identify) Examples: _____ _____
Cognitive	☐Dementia ☐Delirium ☐Distractible ☐Poor Decision Making/Judgment Examples: _____ _____
Development Disorders	☐Autism Spectrum ☐Cognitive Impairment Examples: _____ _____
Disruptive Behaviors	☐Oppositional/Conduct ☐Impulsivity ☐Hyperactivity ☐Aggressive ☐Attention ☐Angry Outbursts Examples: _____ _____
Substance	☐Use ☐Abuse Specify:_____
Other Symptoms	Specify:_____ _____

K: CURRENT MEDICATIONS AND PRESCRIBER *(If PRN, specify use and frequency)*

Instructions for BHCM Initial Mental Health Treatment Form

A. MEMBER INFORMATION: Name **and** Date of Birth are **essential**—please ensure correct spelling and DOB; lack of this identifying information will delay processing.

Member Number: This is the individual's Quartz Insurance ID number. It is okay to leave blank if you don't have this information.

B. REFERRAL SOURCE/REQUESTING CLINICIAN: This is the name of the provider/facility completing this form. Please provide your phone number **&** fax number.

C. REQUESTED TREATMENT PROVIDER INFORMATION: This is the provider/facility/program to whom the member is being referred.

Facility Name/Provider Name: Include both if you have them; if you only know the program/facility you're referring to, put that information in this space.

Facility Address: If this is a Quartz in-network provider, please be sure to put the city name for location. If this is an out-of-network location (non-Quartz provider), please include the address of the facility.

Contact Name/Phone/Fax: If you are a facility/program making an internal referral, please complete this information for the **Requested Treatment** program. If you are referring to a provider/program outside of your own facility, it is okay to leave blank.

D. TYPE OF SERVICE BEING REQUESTED:

TMS: Do not use this form to request PA for TMS. BHCM can provide you with a specific form if you are requesting authorization for TMS.

Outpatient: Outpatient requests are used for outpatient psychotherapy or medication management. A prior authorization (PA) is only required if the request is for services with an out-of-network provider.

In-Home Family Therapy: The intent of the services is to provide the clinical intervention and support necessary to successfully maintain a child or adolescent in their home/community. In-home services can be utilized with families where providing services in the home is the most effective strategy for addressing a specific symptom or issue.

Intensive Outpatient Program (IOP): IOP can be offered in the day or evening hours and can be a step-down from a more restrictive level of care or a step-up to prevent a need for a more restrictive level of care. Treatment is a minimum of 9 hours per week.

Partial Hospital Program (PHP): A PHP is a less restrictive alternative to inpatient care for individuals presenting with acute symptoms of a severe psychiatric disorder who cannot be effectively treated in a less restrictive level of care and would otherwise require inpatient treatment. Often, PHP is recommended when an individual is unable to work, attend school, and/or parent due to the intensity of their symptoms. Treatment is typically 5 or more days per week, 5 or more hours per day.

Residential: Residential provides medical monitoring and 24-hour individualized treatment to a group of individuals. Residential is recommended when an individual is experiencing functional impairments in both relationships and performance of daily role(s). There is a lack of evidence to support the

effectiveness of this level of treatment over less restrictive levels of care for individuals with a viable living environment; therefore, it is only recommended in cases where an individual cannot be managed safely in the community yet doesn't require the services of an inpatient hospitalization.

Inpatient: Inpatient refers to acute psychiatric treatment in an acute care or psychiatric hospital unit. Inpatient hospitalization provides 24-hour medical monitoring and psychiatric treatment.

E. SERVICE INFORMATION:

Mental Health: Any non-AODA mental health condition

Dual: Any program that specifically addresses AODA issues within the context of a mental health condition

Eating Disorder: There is a supplemental form that also needs to be completed if the individual is being referred specifically to an eating disorder program.

Number of Visits/Days Requested: This is typically only completed by a program/facility. Individual providers can leave this section blank.

Begin/End Date of Requested Service: This is typically only completed by a program/facility. Individual providers can leave this section blank.

F. DSM-5/ICD-10 CODES AND DESCRIPTION: Provide specific code as well as any subtypes and/or specifiers.

G. BRIEF DESCRIPTION AND REASON FOR CURRENT TREATMENT REQUEST: Specific examples of symptoms & situation are helpful.

H. CURRENT RISK: Specific examples are **required**.

I. FUNCTIONAL IMPAIRMENTS: Specific examples are **required**.

J. PRIMARY SYMPTOMS AND CORRESPONDING EXAMPLE(S): Specific examples are **required**.

K. CURRENT MEDICATIONS AND PRESCRIBER: Specify any recent changes or significant information.