Behavioral Health Care Management
Initial AODA Treatment Request

Please write clearly and legibly — complete all sections.
See accompanying instructions on pages 3 and 4.

2650 Novation Parkway ▪ Madison, WI 53713
(800) 683-2300 ▪ Fax (608) 471-4391
QuartzBenefits.com

A: MEMBER INFORMATION		
Name:	Date of Birth:	
Member Number:	Admit date (if already admitted):	
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 Location:		
Contact Name:	Phone:	Fax:

D: TYPE OF SERVICE BEING REQUESTED

☐Inpatient Rehabilitation / Detox ☐Residential ☐PHP ☐IOP ☐Outpatient

E: SERVICE INFORMATION	
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 PROBLEM DESCRIPTION AND SUBSTANCE USE PATTERN
Include last date of use, recent pattern of use, how use had affected daily functioning and most recent treatment.

H: COMPLETE ALL 6 DIMENSIONS OF THE ASAM CRITERIA TO JUSTIFY THE LEVEL OF CARE REQUESTED	
Dimension 1: Acute Intoxication and / or Withdrawal Potential	Describe the type and intensity of withdrawal management services needed if applicable. List CIWA and / or COWS / OOWS scores if appropriate.
Dimension 2: Biomedical Conditions and Complications	Include any diagnosed medical conditions or diseases.
Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications	Include any mental health diagnoses and / or objective assessment tool scores.
Dimension 4: Readiness to Change	Include the patient's current stage of change and current treatment participation.
Dimension 5: Relapse, Continued Use or Continued Problem Potential	Include the patient's understanding of relapse and his or her knowledge of skills to interrupt relapse or continued use.
Dimension 6: Recovery Environment	Include whether or not the patient is engaged in community support groups like AA, NA, Smart Recovery, etc. Describe patient's living environment as well as family / peer relationships.

Instructions for BHCM Initial AODA Treatment Request

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.
Admit Date: Only need to complete if member has already admitted to the requested treatment services.

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

Last date seen by referring provider: Last date seen by the provider completing the form.

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 Location: 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:

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.
Intensive Outpatient Program (IOP): The program is 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 need for a more restrictive level of treatment and is considered a Level 2.1 by the American Society of Addiction Medicine. Treatment is a minimum of 9 hours per week.
Partial Hospital Program (PHP): A Partial Hospital Program (PHP) is a time limited, ambulatory treatment program that is offered in the day or evening hours. PHP is often referred to as "day treatment," or acute day hospital, offers at least 20 hours of clinically intensive programming within a licensed health care facility, and is considered a Level 2.5 by the American Society of Addiction Medicine.
Residential: This level of care is also referred to as clinically managed high intensity residential services and is considered a Level 3.5 by the American Society of Addiction Medicine. Services are provided 24 hours a day, 7 days a week in a health care facility licensed for residential substance use disorder treatment.
Inpatient Rehabilitation / Detox: This level of care provides 24-hour evaluation and withdrawal management in a hospital−based inpatient program under the supervision of a physician; however, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. Inpatient Rehabilitation is considered a Level 3.7 by the American Society of Addiction Medicine.

E. SERVICE INFORMATION

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 PROBLEM DESCRIPTION AND SUBSTANCE USE PATTERN: Specific examples of symptoms and situation are helpful. Include last date of use, recent pattern of use, how use had affected daily functioning, and most recent treatment experience.

H. ASAM CRITERIA: For each dimension, identify the severity of risk and the least restrictive level of care indicated.

Dimension 1: What type and intensity of withdrawal management services are needed? Are there current signs of withdrawal? Include scores from withdrawal rating scales if applicable. Are there sufficient supports to assist member if ambulatory withdrawal management is indicated?
Dimension 2: Are there current physical illnesses or chronic conditions that need to be stabilized and / or addressed prior to or during treatment? Does any condition impact the member's past or current substance use?
Dimension 3: Are there any mental health diagnoses or symptoms that need to be stabilized and / or addressed prior to or during treatment? Describe current coping skills related to emotional issues.
Dimension 4: How ready, willing, or able is the member to make changes necessary for recovery? What is member's level of awareness regarding their relationship to substance use and impact on their life?
Dimension 5: What is current awareness of relapse, triggers, and recovery skills? What are current concerns for relapse?
Dimension 6: Do any family members / significant others or school / work situations pose a threat to member's safety or treatment engagement? What is the current level of sober support? What is the current living situation?