Behavioral Health Care Management

Eating Disorder Supplemental Request and Instructions

COMPLETE ALL SECTIONS (A-E) See Accompanying Instructions on Page 2

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: CLINICAL INFORMATION / VITALS		**Date vitals taken:**_____
Height: _____**ft.** _____**in.**	**Weight:**	**Weight Change in Last 30 Days/Since Last Review:**
BMI:	*Current:* _____ *lbs.*	*Describe:*_____
% Ideal Body Weight (IBW):	*Highest:* _____ *lbs.*	_____
	Lowest: _____ *lbs.*	

Orthostatic Vitals:	**BP**
Sitting:	BP_____ / _____ HR_____
Standing:	BP_____ / _____ HR_____
Lying Down:	BP_____ / _____ HR_____

Temperature:

Nasogastric or other special feeding necessary?
☐ No ☐ Yes /Specify:_____
_____

Abnormal EKG: ☐ No ☐ Yes
Specify_____
_____
_____

C: LABS: Provide value of any *ABNORMAL* results below			
Glucose:	Sodium:	Calcium:	CO2:
Albumin	BUN:	Phosphates:	Total Bilirubin:
AST:	Chloride:	Potassium:	Magnesium:
ALT:	Creatinine:	Protein:	

D: CO-OCCURRING MEDICAL CONDITION(S) (i.e. diabetes, seizures, pregnancy, etc.)

E: EATING DISORDER BEHAVIORS/COMPLICATIONS

Restricting/ Food Ritual (i.e. counts calories, restricts # of calories, restricts food groups, skips meals, fasts, water only)
☐ No ☐ Yes Frequency:_____ Explain:_____
_____
_____

Purging (i.e. eliminates, laxative use, diuretic use, self-induced vomiting, over-exercise)
☐ No ☐ Yes Frequency:_____ Explain:_____
_____
_____

Has the patient been hospitalized in the last 30 days due to eating disorder complications? ☐ No ☐ Yes
Explain:_____
_____
_____

Preoccupation / Fear regarding body image, food, weight gain: ☐ No ☐ Yes Explain:_____
_____
_____

Subjective/Objective Binge: ☐ Eats Alone (secretive) ☐ Hides Food ☐ Buys binge food ☐ Night Eating

Instructions for BHCM Eating Disorder Supplemental Request

(This form is completed **in addition** to the BHCM initial or extension request 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 Insurance ID number. It is okay to leave blank if you don't have this information.

B. **CLINICAL INFORMATION/VITALS: (be sure to include date the vitals were taken)**
Height: feet/inches
BMI: Current information
% Ideal Body Weight (IBW): Current information
Weight: Current information
Weight change: If this is a 1st review for this level of care, include weight change in past 30 days; if this is an extension request, include weight change since the last review.
Orthostatic Vitals: Blood pressure (BP) and heart rate (HR) when sitting, standing, and lying down.
Temperature: Current information
Nasogastric or other special feeding necessary: If yes, please describe.
Abnormal EKG: If yes, specify.

C. **LABS:** Only **ABNORMAL** results need to be provided.

D. **CO-OCCURRING MEDICAL CONDITION(S):** Current information

E. **EATING DISODER BEHAVIORS/COMPLICATIONS:** Specific examples are **required.**