FIDELIS CARE®

Behavioral Health Service Request Form

Inpatient, Sub-acute and CSU Services

Please Submit to the Dedicated Fax Line Below

Medicaid
Call for Pre-Certification of Admissions: 888-453-2534
New Jersey Medicaid Fax: 855-703-8082

☐	Retro Request	Please indicate if the services are completed and the member is no longer in Inpatient care. Please submit the member record for review.
Level of Care:	☐ Inpatient ☐ Sub-acute ☐ CSU	
Place of Service:	☐ 21-Inpatient Hospital ☐ 51-Inpatient Psychiatric Hospital ☐ 53 - Community Mental Health Center	

Please contact Fidelis Care for authorization of Inpatient services at the time of admission or on the next business day following admission to a psychiatric Inpatient program. After the initial authorization determination, providers will be required to perform concurrent review for any additional Inpatient days authorized. This form should be used by providers to ensure our review process will be as quick and efficient as possible.

MEMBER INFORMATION					
Last Name		First Name, Middle Initial		Date of Birth	
Phone Number		ID Number		Gender	☐ Male ☐ Female
Third-Party Insurance	☐ Yes ☐ No	If **Yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.		Languages Spoken	

TREATING PROVIDER/PRACTITIONER INFORMATION					
Last Name		First Name		NPI Number	
ID Number		Participating	☐ Yes ☐ No	Discipline/Specialty	
Street Address		City, State		ZIP	
Phone Number		Fax Number		Office Contact	

FACILITY/AGENCY INFORMATION					
Name		Facility ID		NPI Number	
Street Address		City, State		ZIP	
Phone Number		Fax Number		Office Contact	

SERVICE TYPE REQUESTED	REV/HCPCS Code(s)			
Service Type:	REV/HCPS Code :			
Detox				
Rehab				
Service Request Start Date:	Projected Length of Stay:	Original Admission Date (if different from Start Date Requested):	Transition of Care ☐ Yes ☐ No	Continuation of Care ☐ Yes ☐ No

DIAGNOSIS - Code and Description	
Primary Diagnosis	
Secondary Diagnosis	

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Medical Diagnosis	

Are services requested court ordered? ☐ Yes ☐ No *If yes, please submit a copy of the court order and all supporting documentation.*

REASON FOR ADMISSION

Presenting problem to be addressed by treatment plan:

Date problem began		Duration		Is member under the care of a psychiatrist	☐ Yes ☐ No
Is member currently inpatient	☐Yes ☐ No	If yes, what is the current length of stay?			

Is member currently receiving Outpatient services?
☐ Yes ☐ No

If yes :

Name of Provider / Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

☐	I acknowledge that I am required to send a report of the member's admission to inpatient services to their PCP, and I will update their PCP quarterly.

CURRENT RISK

Risk level scale: 0 = none; 1 = mild, ideation only; 2 = moderate, ideation with either a plan or history of attempts; 3 = severe, ideation AND plan, with either intent or means.

Check the risk level for each category and check all boxes that apply.

Risk to self (SI)	☐ 0 ☐ 1 ☐ 2 ☐ 3	With ☐ ideation ☐ intent ☐ plan ☐ means	
Risk to others (HI)	☐ 0 ☐ 1 ☐ 2 ☐ 3	With ☐ ideation ☐ intent ☐ plan ☐ means	
Current serious attempt or non-suicidal self-injury:	☐ Yes ☐ No (If yes, describe below)	Check: ☐ SI ☐ HI	Date of most recent attempt:

If checked yes above, please describe:

Prior serious attempt or nonsuicidal self-injury:	☐ Yes ☐ No (If yes, describe below)	Check: ☐ SI ☐ HI	Date of attempt:

If checked yes above, please describe:

CURRENT IMPAIRMENTS

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed

Check the impairment level for each category and please provide brief description of any severe (3) impairments.

Mood Disturbance (depression, mania):	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Anxiety:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

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Psychosis	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Thinking/cognition/memory	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Impulsive/recklessness/aggressive	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Activities of daily living	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Weight change associated with behavioral health diagnosis ☐ gain ☐ loss _____ lbs in past three months	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Medical/physical conditions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Substance abuse/dependence	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Job/school performance	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Social/marital/family problems	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Legal	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Stressors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Orientation/alertness/awareness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

CURRENT/PREVIOUS TREATMENT

Is a psychiatrist involved in the member's care? ☐ Yes ☐ No

If yes, when was the member last seen and what services are being rendered?

History of hospitalization in the past year? ☐ Yes ☐ No

Name of Facility	Dates

Is a therapist currently involved in the members care? ☐ Yes ☐ No

Name of Current Provider/Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Please list any other treatment received over the past two years:

Name of Provider/Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

CURRENT MEDICATIONS (Psychotropic and Medical)

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Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe:			

ADDITIONAL CLINICAL INFORMATION

Is the member at risk of legal intervention or out-of-home placement? Describe:
Describe the overall risk of harm (to self or others):
What are the environmental/community stressors and/or supports that contribute to the member's clinical status?
Support System (describe):
Describe the member/family engagement in treatment:
Current living situation: ☐ homeless ☐ independent ☐ family ☐ foster home ☐ incarcerated ☐ other:
Detail the discharge plan: