

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 Re	equest	Please indicate if the services are completed and the member is no longer in Inpatient care. Please submit the member record for review.
Levelo	f Care:	🗆 Inpatie	nt 🗆 Sub-acute 🛛 CSU
Place of	f Service:	🗆 21-Inp	atient Hospital 🛛 51-Inpatient Psychiatric Hospital 🛛 53 - Community Mental Health Center
a psych	iiatric Inpatier nal Inpatient d	t program. <i>I</i>	uthorization of Inpatient services at the time of admission or on the next business day following admission to After the initial authorization determination, providers will be required to perform concurrent review for any zed. This form should be used by providers to ensure our review process will be as quick and efficient as

					MEMBER	INFORMATION					
Last Name				First Na Initial	ame, Middle				Date o	of Birth	
Phone Number				ID Num					Gende	ər	🗆 Male 🛛 Female
Third-Party Insurance	□Yes	□ No	is not ava and num	ailable, pr ber.	ovide the nai	the insurance card. I me of the insurer, po	licy type	Lan Spo	iguages oken	5	
	-		TREATI		OVIDER/P	RACTITIONER	INFOR	MATIC	ON		
Last Name				FirstNa	ame				NPI Nu	umber	
ID Number				Partici	pating	□Yes □No		Disc	ipline/S	Specialty	
Street Address					City, State					ZIP	
Phone Number				Fax Nu	mber			Office 0	Contact	t	•
				FACI	LITY/AGE	NCY INFORMA	TION			ľ	
Name				Facility	ID				NPI Nu	umber	
Street Address					City, State					ZIP	
Phone Number				Fax Nu	mber			Office 0	Contact	t	
SERVICE TY REQUESTE		REV/H	CPCS Co	ode(s)							
Service Type:		REV/HCF	S Code :								
Detox											
Rehab											
Service Reque Start Date:	st	Projecte	d Length of	f Stay:		dmission Date t from Start Date l):	Transi	ition of	Care	Con	tinuation of Care
							🗆 Y	∕es 🗆	No		🗆 Yes 🛛 No
				DIAG	NOSIS <u>- C</u>	ode and Descr	iption				
Primary Diagnosis											
Secondary 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? Yes No If yes Is member currently inpatient services? Yes No Yes No If yes No If yes, what is the current length of stay? Yes No If yes No Yes No Yes No If yes If yes Compliant Yes No If yes If yes No Yes No If yes If yes If yes No Yes No If yes If yes If yes No Yes No If yes If yes If yes If yes No Yes No If yes <	Medical Diagnosis								
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non-suicidal self-injury: (If yes, describe below) Check: SI HI Date of hidstrecent attempt. If checked yes above, please describe: Prior serious attempt or nonsuicidal self-injury: Yes No Check: SI HI Date of attempt: If with the second s	()			s w	ith 🗆 ideation 🗆 inte	ent 🗆 plan	means		
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: If checked yes above, please describe: 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		or			Check: 🗆 SI 🛛 I	HI Date of	of mostrecen	it attempt:	
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Check the impairment level for each category and please provide brief description of any severe (3) impairments. Mood Disturbance (depression, mania):			CUP	RRENT I	MPAIRMENTS				
Mood Disturbance (depression, mania): ^O	Scale: 0 = none; 1 = mil	d; 2 = m	oderate; 3 = severe; N/A = i	not assess	sed				
Mood Disturbance (depression, mania): ^O	Check the impairment le	v el for e	ach category and please p	rovide brie	f description of any sev	ere (3) impair	ments.		
Anxiety:					*			2 🗆 3 🗆 N	√A
	Anxiety:						0 1	2 <u>3</u> 1	N/A



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 three months	⊐ gain □	lossIbs in past	□ 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/	PREVIO	US 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 rende	ered?		
History of hospitalization in the past year? Yes No				
Name of Facility			Dates	
Is a therapist currently involved in the members care? $\$ \Box Yes	🗆 No			
Name of Current Provider/Facility	Dates	5	Со	mpliant
			🗆 Yes	
			🗆 Yes	s 🗆 No
			🗆 Yes	s 🗆 No
Please list any other treatment received over the past two year	's:			
Name of Provider/Facility		Dates		Compliant
			[🗆 Yes 🗆 No
			[🗆 Yes 🗆 No
			[🗆 Yes 🗆 No
			[□Yes □No
			[□Yes □No
			[□Yes □No
	1			-
CURRENT MEDICAT	CIONS (P	sychotropic and Medi	cal)	



	Medication	Dosage	Frequency	Compliant
				🗆 Yes 🗆 No
				🗆 Yes 🗆 No
				🗆 Yes 🗆 No
				🗆 Yes 🗆 No
	Are there any medication	n contraindications? If yes,	please describe:	
		ADDITIONA	L CLINICAL INFORMATION	
s the me	mber at risk of legal interv	vention or out-of-home place	cement? Describe:	
escribe	the overall risk of harm (t	o self or others):		
escribe	the overall risk of harm (t	o selfor others):		
escribe	the overall risk of harm (t	o selfor others):		
	· · · · · · · · · · · · · · · · · · ·		norts that contribute to the member's c	linical status?
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Vhat are	· · · · · · · · · · · · · · · · · · ·		ports that contribute to the member's c	linical status?
Vhat are Support S	the environmental/comm	nunity stressors and/or sup	ports that contribute to the member's c	linical status?
Vhat are Support S	the environmental/comm System (describe):	nunity stressors and/or sup	ports that contribute to the member's c	linical status?
What are Support S	the environmental/comm System (describe):	nunity stressors and/or sup	ports that contribute to the member's c	linical status?
Vhat are Support S	the environmental/comm System (describe):	nunity stressors and/or sup	ports that contribute to the member's c	:linical status?
What are Support S	the environmental/comm System (describe): the member/family engag	gement in treatment:	ports that contribute to the member's o	
Vhat are Support S Describe	the environmental/comm System (describe): the member/family engag	gement in treatment:		