bridgespan®

Behavioral Health Utilization Management

Initial Request Form

Instructions:

- This form is used to request inpatient, residential, partial hospital, and intensive outpatient treatment.
- Please submit via email: FAXBHRepository@bridgespanhealth.com or Fax: 888-496-1540.
- Out-of-network providers, please attach a copy of any applicable state license, CARF or Joint Commission accreditation for the requested level of care.
- Expedited request definition: *When the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health, or ability to regain maximum function in serious jeopardy.* Is this an Expedited Request? ☐ Yes ☐ No
- Is this a Medicare Preservice Benefit Organization Determination Request? ☐ Yes ☐ No

Today's Date:	Member ID #:

Member information	
Member Name:	Member DOB:
Member address:	Member phone #:

Autohorization Request

Please choose only one level of care.

Mental Health - (includes eating disorder)

☐ Level 6 - Inpatient ☐ Level 5 - Residential ☐ Level 4 - Partial Hospital ☐ Level 3 - Intensive Outpatient

Substance Use Disorder

☐ ASAM 4. ☐ ASAM 3.7. ☐ ASAM 3.5. ☐ ASAM 2.5. ☐ ASAM 2.1. ☐ Other: _____

For PHP and IOP: specify program frequency (# of days per week): _____

Admit or projected start date: Has member admitted? ☐ Yes or ☐ No	Days Requested:	Estimated Length of Stay:

Diagnosis: ICD-10 code and description.

Please indicate primary:

Utilization Reviewer			
UR / Contact Name:	Phone #:	Confidential voicemail ☐ Yes ☐ No	Fax #:

Who should we call for possible MD review?

☐ UR noted above ☐ Provider Name & Phone:

Facility information		
Rendering Facility Name:	NPI #:	Tax ID #:
Treatment Facility Address:	Phone #:	Fax #:
Attending physician first and last name:	Attending physician phone #:	
Requesting Provider Name: ☐ Same as above	NPI #:	Tax ID #:
Provider Address:	Phone #:	Fax #:

Mental Health Treatment Request ☐ Not applicable If no information is provided in a particular section, then I attest there is no significant clinical impairment.
Precipitant to Admission:
For Eating Disorders: Weight. BMI. Vitals. ☐ Not applicable
Risk Assessment: ☐ None reported
Functional Status: ☐ None reported

Medical, Substance Use or Psychiatric Co-Morbidities:	☐ None reported

Recovery Environment: (home / living environment and supports).	☐ None reported

Previous treatment / Motivation for Treatment / Treatment engagement.	☐ None reported

Substance Use Treatment Request: American Society of Addiction Medicine (ASAM) assessment.	☐ Not applicable
Substance Use: (please detail all substances used; amount, frequency, and date of last use.)	
Dimension 1. Acute intoxication and/or withdrawal potential (please include CIWA / COWS / Vitals):	
Dimension 2. Biomedical conditions and complications.	

Dimension 3. Emotional, behavioral, or cognitive complications.

Dimension 4. Readiness to change.

Dimension 5. Relapse, continued use or continued problem potential.

Dimension 6. Recovery living environment.

Treatment Plan

Treatment goals:

Treatment interventions: (include family treatment and community referrals) (please include family session notes with submission).

Individual session frequency: _____.

Family session frequency: _____.

Psychiatric visit frequency: _____.

Medications: (please specify last medication appointment and current medications)

Discharge Planning	
Discharge planner name:	Phone:
Aftercare plan:	
Additional Information:	
Submitted by:	Phone: