ASURIS NORTHWEST HEALTH

Behavioral Health Utilization Management

Stepdown Request Form

This form is used to request immediate stepdown authorization from a higher level of care to a lower level of care.

Please submit via email: FAXBHRepository@asuris.com or Fax: 888-496-1540

Expedited request: I attest that this request meets the below definition by checking the expedited request box: ☐

Expedited is defined as: 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 for a Medicare Preservice Benefit Organization Determination Request? ☐ Yes ☐ No

Today's Date:	Member ID #:	Current Authorization #:
Current Level of Care:	Discharge Date:	

Request stepdown authorization:

Mental Health level of care requested

☐ Residential (RES) ☐ Partial Hospital (PHP) ☐ Intensive Outpatient (IOP)

☐ RES - eating dis. ☐ PHP - eating dis. ☐ IOP - eating dis.

Substance Use Disorder level of care requested

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

For PHP & IOP - specify program frequency (# of days per week):

Stepdown admit date:	Days Requested:	Estimated Length of stay:

Member information

Member Name:	Member DOB:

Facility information ☐ **Same Facility / No Change** ☐ **See Changes below**

Facility name:	Tax ID #:	
NPI #:	Office Phone #:	Office Fax #:
Physical Address:		
Attending physician first and last name:		Attending physician phone #
Who should we call for possible MD review? Name & Phone Number:		

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

ICD-10 diagnoses. Please indicate primary.

Clinical Update since last review — symptoms, risk factors, functional impairments.

Co-occurring medical / physical illness updates

(Please explain how these are being addressed)

For Eating Disorders: Updated Weight, BMI, Vitals

☐ Not applicable

Updated assessment of American Society of Addiction Medicine (ASAM)
☐ **Not applicable**

Substance Use: please detail all substances used; amount, frequency, and date of last use.

Dimension 1. Acute intoxication and/or withdrawal potential.

Describe: (include vitals and withdrawal symptoms):
CIWA / COWS:
Vitals:

Dimension 2. Biomedical conditions and complications.

Describe:

Dimension 3. Emotional, behavioral, or cognitive complications.

Describe:

Dimension 4. Readiness to change.

Describe:

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

Describe:

Dimension 6. Recovery living environment.

Describe:

If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?

☐ Not applicable

Discharge Planning

Discharge planner name:	Phone:

Aftercare plan:

Please list any outstanding items needing attention for next review.

Treatment Plan

Updated treatment goals / Progress toward goals:

Updated treatment interventions:

Updated / Current Medications:

Submitted by:	Phone: