Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Behavioral Health Concurrent Review Form for Mental Health Inpatient

Please note, this form applies to Anthem HealthKeepers Plus Medicaid products offered by HealthKeepers, Inc.

Please submit your request electronically using our preferred method via Availity Essentials* at **availity.com**. If you choose to fax this form instead, you may send it to **844-445-6646**.

Date:		
Contact information		
Level of care: ☐ Inpatient mental health		
Member name:	Member ID or reference #:	Member DOB:
Member address:	Member phone #:	
Hospital account #:	Name of parent/guardian (if needed):	Primary spoken language:
Name of utilization review (UR) contact:	UR phone number:	
Admit date:	UR fax number:	
☐ Voluntary ☐ Involuntary — If involuntary, date of commitment:		
Admitting facility name:	Admitting facility provider # or NPI:	
Attending physician full name:	Attending physician phone #:	
Provider # or NPI:	Facility unit:	Facility phone #:
Discharge planner name:	Discharge planner phone #:	

***** Availity, LLC is and independent company providing administrative support services on behalf of HealthKeepers, Inc.

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Diagnoses (psychiatric, chemical dependency, and medical)	
Risk of harm to self (within last 24 to 48 hours)	**Risk rating (check all that apply)**
If present, describe: If prior attempt, note date and description of attempt:	☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt
Risk of harm to others (within last 24 to 48 hours)	**Risk rating (check all that apply)**
If present, describe: If prior attempt, note date and description of attempt:	☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt
Psychosis (within last 24 to 48 hours) **Risk rating: 0 = None** **1 = Mild or mildly incapacitating** **2 = Moderate or moderately incapacitating** **3 = Severe or severely incapacitating** **N/A = Not assessed**	**Symptoms (check all that apply)**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A If present, describe:	☐ Auditory/visual hallucinations ☐ Paranoia ☐ Delusions ☐ Command hallucinations
Substance use **Risk rating: 0 = None** **1 = Mild or mildly incapacitating** **2 = Moderate or moderately incapacitating** **3 = Severe or severely incapacitating** **N/A = Not assessed**	**Substance (check all that apply):**
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A If present, describe last use, frequency, duration, and sober history:	☐ Alcohol ☐ Barbiturates ☐ Cocaine ☐ Benzodiazepines ☐ Opioids ☐ Marijuana ☐ Methamphetamines ☐ PCP ☐ LSD ☐ Other (describe):

Current treatment plan

Medications

Have medications changed (type, dose, and/or frequency) since admission? ☐ Yes ☐ No
If yes, give medication, current amount, and change date:

Have any as needed (PRN) medications been administered? ☐ Yes ☐ No
If yes, give medication, administration date, and current amount:

Member's participation in and response to treatment

Is the member attending groups? ☐ Yes ☐ No ☐ N/A

Does the member have family or other supports involved in treatment? ☐ Yes ☐ No ☐ N/A

Is the member adherent to medications as ordered? ☐ Yes ☐ No ☐ N/A

Member is improving in (check all that apply):

☐ Thought processes
☐ Affect
☐ Mood
☐ Performing activities of daily living (ADLs)
☐ Impulse control/behavior
☐ Sleep

Support system
List coordination activities with case managers, family, community agencies, and so on. If case is open with another agency, provide the name of the agency, the agency phone number, and case number.

Discharge plan
Note changes and barriers to discharge planning in these areas and plan for resolving barriers.
If a recent readmission, indicate what is different about the plan from last time.

Housing issues:

Psychiatry:	
Therapy and/or counseling:	
Medical:	
Wraparound services:	
Substance use services:	
Planned discharge level of care:	
Expected discharge date:	
Submitted by:	**Phone #:**

If you have any questions about this communication, call Anthem HealthKeepers Plus Provider Services at **800 901 0020**.