

Behavioral Health Initial Review Form for Mental Health Inpatient

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

Please submit your request electronically via 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.

Member address: Hospital account #: For child/adolescent, name of parent/guardian: Name of utilization review (UR) contact: UR phone number: UR phone number:	Today's date:					
Member name: Member ID or reference #: Member DOB: Member address: Member phone #: Hospital account #: For child/adolescent, name of parent/guardian: Name of utilization review (UR) contact: UR phone number: Admit date: UR fax number: I voluntary Involuntary Involuntary, date of commitment: Admitting facility name: Attending physician (first and last names): Facility provider # or NPI: Attending physician (first and last names): Facility unit: Facility phone #: Discharge planner phone #: Diagnosis (Psychiatric, chemical dependency, and medical)	Contact information					
Member address: Hospital account #: For child/adolescent, name of parent/guardian: Primary spoken language: UR phone number: UR phone number: UR phone number: UR phone number: Admit date: UR fax number: Voluntary Involuntary Involuntary Facility provider # or NPI: Attending physician (first and last names): Provider # or NPI: Facility unit: Facility phone #: Discharge planner name: Discharge planner phone #:	Level of care:	patient psych				
Hospital account #: For child/adolescent, name of parent/guardian: Primary spoken language: Name of utilization review (UR) contact: UR phone number: Admit date: UR fax number: Involuntary Involuntary Gate of commitment: Admitting facility name: Facility provider # or NPI: Attending physician (first and last names): Attending physician phone #: Provider # or NPI: Facility unit: Facility phone #: Discharge planner name: Discharge planner phone #:	Member name:			Member ID or reference #:		Member DOB:
Hospital account #: For child/adolescent, name of parent/guardian: Primary spoken language: Name of utilization review (UR) contact: UR phone number: Admit date: UR fax number: UR fax number: Voluntary Involuntary Involuntary Involuntary Involuntary, date of commitment:						
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Diagnosis (Psychiatric, chemical dependency, and medical)	Provider # or NPI:		Facility unit:		Facility phon	e #:
	Discharge planner name:		Discharge planner phone		anner phone #:	
Precipitant to admission (Be specific. Why is the treatment needed now?)	Diagnosis (Psychiatric, c	hemical dependency, an	d medical)			
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^{*} Availity, LLC is an independent company providing administrative support services on behalf of HealthKeepers, Inc.

Risk of harm to self				
If present, describe:				
If prior attempt, note of	date and description of attemp	pt:		
Risk rating (Select all	that apply.): ☐ Not present ☐	☐ Ideation ☐ Plan ☐ I	Means □ Prior attempt	
Risk of harm to other	ers			
If present, describe:				
If prior attempt, note of	date and description of attemp	pt:		
Risk rating (Select all	that apply.): ☐ Not present ☐	☐ Ideation ☐ Plan ☐ I	Means □ Prior attempt	
Psychosis				
• ,	, 1 = Mild or mildly incapacita		moderately incapacitation	ng,
3 = Severe or severe	ly incapacitating, N/A = Not as	ssessed):		
3 = Severe or severe □ 0	•		moderately incapacitation	ng, □ N/A
3 = Severe or severe	ly incapacitating, N/A = Not as	ssessed):		
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3 = Severe or severe □ 0 If present, describe:	ly incapacitating, N/A = Not as □ 1	ssessed):		
3 = Severe or severe □ 0 If present, describe: Symptoms (Select all	ly incapacitating, N/A = Not as □ 1 that apply.):	ssessed):	□3	
3 = Severe or severe □ 0 If present, describe: Symptoms (Select all □ Auditory/visual hall	ly incapacitating, N/A = Not as □ 1	ssessed):	□3	
3 = Severe or severe □ 0 If present, describe: Symptoms (Select all □ Auditory/visual hall Substance use	that apply.): ucinations □ Paranoia □ De	ssessed): □ 2 elusions □ Comman	□ 3	□ N/A
3 = Severe or severe □ 0 If present, describe: Symptoms (Select all □ Auditory/visual hall Substance use Risk rating (0 = None,	that apply.): ucinations □ Paranoia □ De 1 = Mild or mildly incapacitat	elusions Comman	□ 3	□ N/A
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Previous treatment (Include provider name, facility name, medications, specific treatment/levels of care, and adherence.)
Current treatment plan
Standing medications:
As-needed medications administered (not ordered):
Other treatment and/or interventions planned (including when family therapy is planned):
Support system (Include coordination activities with case managers, family, community agencies, and so on. If case open with another agency, provide the agency name, phone number, and case number.)
Results of depressions screening
Initial discharge plan (List name and number of discharge planner and include whether the member can return to current residence.)
Planned discharge level of care:
Describe any barriers to discharge:
Expected discharge date:
Submitted by: Date:

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