Behavioral Health Crisis Services Treatment Request Form

Submit completed form electronically using our preferred method at **Availity** or by fax to **1-833-974-0059**.

Today's date:	
Contact at provider's office:	Secure fax:
Name of requestor:	Phone:
Please note: Provide appropriate contact information, including best working phone number for Humana staff to contact you if clarification or additional information is needed to complete the request.	

Member information		
Last name:	First name:	
Humana ID:	Medicaid ID:	Date of birth:
Member's living arrangements:		Phone:
Is the member currently in coordinated system of care (CSoC)? ☐ Yes ☐ No		
Authorization reference number (if applicable):		

Requesting provider/facility		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Treating/servicing provider		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Services	
☐ Crisis intervention—follow-up	☐ Community brief crisis support (CBCS)
☐ Behavioral health crisis care (BHCC)	☐ Crisis stabilization

Humana
Healthy Horizons®
in Louisiana

Diagnosis code(s) and date(s) of service (DOS)			
ICD-10*:	ICD-10*:	ICD-10*:	ICD-10*:
Start date of service:		End date of service:	
Type of request: ☐ Initial request ☐ Concurrent request			

* International Classification of Diseases, Tenth Edition.

Service code(s) including modifiers as indicated		
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:
Code:	Units:	Frequency:

Names of current behavioral health providers:	
1.	3.
2.	4.

Names of previous behavioral health providers:	
1.	4.
2.	5.
3.	6.

Medications

☐ Check if member is not adherent to medication regimen.

☐ Check if member is not taking any medications.

Current medications (indicate changes since last report)	**Dosage**	**Frequency**

Current risk factors

Suicide:

- ☐ None
- ☐ Ideation
- ☐ Intent without means
- ☐ Intent with means
- ☐ Contracted not to harm self
  Date of contract: _____
- ☐ Access to weapons

Homicide:

- ☐ None
- ☐ Ideation
- ☐ Intent without means
- ☐ Intent with means
- ☐ Contracted not to harm others
  Date of contract: _____
- ☐ Access to weapons

Physical or sexual abuse or child/elder neglect: ☐ Yes ☐ No
If yes, patient is: ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither (but abuse exists in family)

Abuse or neglect involves a child or elder: ☐ Yes ☐ No

Abuse has been legally reported: ☐ Yes ☐ No

Symptoms that are the focus of current treatment (may include specific testing to support and correlate with Diagnostic and Statistical Manual of Mental Disorders [DSM] diagnoses, observations of behavior or chief complaints)

Progress since last review (including what is being reevaluated or changed, whether member is being reassessed, whether there are any medication changes, stressors or supports that may contribute or serve as a barrier)

Functional impairments or strengths (including interpersonal relations, personal hygiene, work/school)—Identify specific behaviors

Describe recovery environment (including support system, level of stress)

Engagement/level of active participation in treatment

Housing

Co-occurring medical/physical illness

Family history of mental illness or substance use

Trauma-informed care—Individuals have experienced potentially traumatic events in their lifetime. It is imperative that everyone be aware of the potential impact of trauma on those they serve, be mindful of how their policies and procedures may affect those who use their services, and be prepared to recognize and offer trauma-specific services when needed.

Is there evidence to suggest this member has experienced trauma? ☐ Yes ☐ No

What is your plan to assess and address the current and potential effects of that trauma?

Patient's treatment history including all levels of care:

Level of care	Number of distinct episodes/sessions	Date of last episode/session
Outpatient—psych		
Inpatient—psych		
Outpatient—substance use		
Inpatient—substance use		
Residential treatment center—substance use		
Residential treatment center—psych		
Crisis services		
Other:		

Treatment goals for each type of service (specify) with expected dates to achieve them
(should correlate with symptoms and DSM diagnoses)

1.
2.
3.
4.
5.
6.

Measured objective outcome criteria by which goal achievement is determined
1.
2.
3.
4.
5.
6.

Discharge plan and estimated discharge date

Expected outcome and prognosis:

- ☐ Return to normal functioning
- ☐ Expect improvement, anticipate less than normal functioning
- ☐ Relieve acute symptoms, return to baseline functioning
- ☐ Maintain current status, prevent deterioration

Treatment plan coordination

I have requested permission from the member/member's parent or legal guardian to release information to the primary care provider (PCP). ☐ Yes ☐ No

If no, provide rationale why release would be inappropriate:

Treatment plan was discussed with and agreed upon by the member/member's parent or legal guardian: ☐ Yes ☐ No

Name of legal guardian (if applicable) and any agencies involved with the member (Department of Children & Family Services, Office for Citizens with Developmental Disabilities, etc.)

Please attach summary sheets of ASAM, LOCUS, CASII, CALOCUS or other applicable assessments that assist in presentation of clinical needs.

Provider signature:	**Date:**

Disclaimer: Authorization indicates that Humana determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.