

Behavioral Health Service Request Form

Member Information

Last Name		First Name		Date of Birth
Phone Number		Humana ID#		Gender Male Female
Third Party Insurance	Yes No	If Yes, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type and number.		Language Spoken

Treating Provider/Practitioner Information

Last Name		First Name		NPI
Humana ID#		Participating	Yes No	Discipline/Specialty
Street Address		City, State		Zip
Phone Number		Fax Number		Office Contact

Facility Information

Name		Facility ID		NPI
Street Address		City, State		Zip
Phone Number		Fax Number		Office Contact

Service Type Requested	List REV/CPT/HCPCS Code(S)	Requested Number of Units (not to exceed a 3-month period)

Diagnosis - Code and Description

Primary Diagnosis
Secondary Diagnosis
Medical Problems

Disclaimer: An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

SCHL9W7EN0721

Humana Healthy Horizons in South Carolina is a Medicaid Product of Humana Benefit Plan of South Carolina, Inc.

Routine Outpatient Services Behavioral Health Service Request Form

Diagnosis - Code and Description

Treatment Phase:	Initiation (0-3 months)	Continuation (3-6 months)	Stabilization/eMaintenance (over 6 months)
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Are services requested court ordered? Yes No

If **yes**, please submit a copy of the court order and all supporting documentation

Risk Factors and Symptoms

Please describe the members baseline behavior :

Inpatient admissions for behavioral health/substance abuse treatment?

Past 12 months

More than 12 months ago

Never

Current Severity Rating

	None	Mild	Moderate	Severe	Explain Rating
Risk of harm to self or others					
Impairment of psychological functioning					
Impairment of social functioning (family/school/work)					
Impairment of physical functioning					
Impairment in support systems					
Other (list)					

If substance abuse identified please provide details:

Name of substance used	Date of first use	Frequency of use	Date of last use

Treatment

Functional Area	Narrative explaining treatment interventions in each functional area of concern:
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	

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Discharge Goal	
Functional Area	Narrative describing discharge goals for each functional area of concern:
Risk of harm to self or others	
Impairment of psychological functioning	
Impairment in social functioning (family/school/work)	
Impairment of physical functioning	
Impairment in support systems	
Other (list)	
Discharge plan (date)	
Adherent to therapy? Yes No	Adherent to medications? Yes No
Please list rationale for additional therapy sessions:	
<p>Has the member made progress in treatment? Yes No If yes, please describe:</p>	
<p>If no, how has the treatment plan been modified accordingly?</p>	
<p>Does member have access to competent and available supports? Yes No Please explain:</p>	
<p>Does the member have transportation to and/or from services? Yes No</p>	
<p>Please submit a copy of the member's most recent Treatment Plan.</p>	