Humana
Healthy Horizons®
in South Carolina

Healthy Connections

Inpatient and partial hospitalization

Please complete form in its entirety and return to:
Email: **CorporateMedicaidCIT@humana.com** Fax: **833-441-0950**

Behavioral Health Service Request Form

Choose one of the following:

☐ Inpatient hospital ☐ Inpatient psychiatric facility ☐ Psychiatric facility – partial hospitalization

Please contact Humana for prior authorization of inpatient services at the time of admission or on the next business day following admission to a psychiatric inpatient program. After the initial authorization determination, providers are required to perform concurrent review for any additional inpatient days authorized. Providers should use this form for a quick and efficient review process.

Member information

Last name		First name	Date of birth
Phone No.		Humana ID No.	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

Ordering physician/practitioner information

Last name	First name	NPI
Humana ID No.	Type ☐ PCP ☐ Specialist	Specialty
Participating ☐ Yes ☐ No	Phone No.	Fax No.
Street address	City, state	ZIP code
Name of requestor	Office contact (if different)	

Treating provider/practitioner information

Last name	First name	NPI
Humana ID No.	Participating ☐ Yes ☐ No	Discipline/specialty
Street address	City, state	ZIP code
Phone No.	Fax No.	Office contact

Facility information

Name	Facility ID No.	NPI
Street address	City, state	ZIP code
Phone No.	Fax No.	Office contact

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

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Inpatient and Partial Hospitalization Behavioral Health Service Request Form

Requested services			
Start date	End date	Original date of admission	Estimated length of stay (days)
Primary ICD-10 code(s)*		Description/condition	
Additional ICD-10 code(s)		Description/condition	
CPT®/HCPCS code(s)†		Description/procedure	
Clinical summary/presenting problem or reason for admission			

* ICD-10 codes are from the International Classification of Diseases, 10th edition.

† CPT/HCPCS codes are part of the Current Procedural Terminology/Healthcare Common Procedure Coding System.

Current symptoms (Check all apply.)

- ☐ Anhedonia
- ☐ Bed wetting
- ☐ Coping with pain
- ☐ Cruelty to animals
- ☐ Delusions
- ☐ Depressed mood
- ☐ Disorientation
- ☐ Distorted thinking
- ☐ Distrustful/suspicious
- ☐ Eating problems
- ☐ Fire setting
- ☐ Generalized anxiety
- ☐ Grandiosity
- ☐ Hallucinations
- ☐ Hopelessness/ helplessness
- ☐ Hyperactivity
- ☐ Impaired attention/ concentration
- ☐ Impaired judgment
- ☐ Impulsivity
- ☐ Irritability
- ☐ Lack of insight
- ☐ Memory impairment
- ☐ Mood swings
- ☐ Motoric disturbance
- ☐ Obsession/compulsion
- ☐ Oppositional
- ☐ Panic attacks
- ☐ Perpetrator
- ☐ Phobia
- ☐ Pressured speech
- ☐ Rage/anger
- ☐ Self-mutilation
- ☐ Sleep disturbance
- ☐ Social isolation
- ☐ Substance abuse/ dependence
- ☐ Suicidal/ homicidal ideation
- ☐ Tantrums
- ☐ Thought disturbance
- ☐ Verbal/physical/ sexual abuse
- ☐ Victim
- ☐ Work/school problems

Rationale
What is the purpose of treatment for this member? Include relevant history.
Identify the treatment goals.
Describe how the treatment plan will affect the treatment outcomes. (Please attach a copy of the current treatment plan.)

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Rationale
Are there other reasons treatment is necessary? If so, please describe.
Is this treatment course or research related to or necessary for admission to a program or school?
Has there been any prior outpatient treatment? ☐ Yes ☐ No If **yes**, please specify the dates.
Was there treatment failure? ☐ Yes ☐ No If **yes**, please specify the previous treatment.
Current medications (Please indicate if the member is compliant.)

Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) diagnosis
Indicate any change in diagnostic presentation.
Provide an updated psychiatric diagnosis
Provide an updated medical diagnosis

Current risks									
Risk level scale: **0** = None; **1** = Mild, ideation only; **2** = Moderate, ideation with either a plan or history of attempts; **3** = Severe, ideation **AND** plan with either intent or means.									
Check the risk level for each category and check all boxes that apply.									
Risk of self (SI)	☐ 0	☐ 1	☐ 2	☐ 3	with	☐ Ideation	☐ Intent	☐ Plan	☐ Means
Risk of others (HI)	☐ 0	☐ 1	☐ 2	☐ 3	with	☐ Ideation	☐ Intent	☐ Plan	☐ Means
Current serious attempt ☐ Yes ☐ No ☐ SI ☐ HI					Prior serious attempt ☐ Yes ☐ No ☐ SI ☐ HI				
Prior serious gestures ☐ Yes ☐ No ☐ SI ☐ HI					Give specific examples				
Date of most recent attempt or gesture:									

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Current impairments	
Scale: **0** = None; **1** = Mild; **2** = Moderate; **3** = Severe; **N/A** = Not assessed	
Check the impairment level for each category.	
Mood disturbance (depression, mania)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Anxiety	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Psychosis	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Thinking/cognition/memory	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Impulsive/reckless/aggressive	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Activities of daily living	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Weight change associated with behavioral health diagnosis ☐ Gain ☐ Loss pounds in last three months	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Medical/physical conditions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Substance use/dependence	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Job/school performance	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Social/marital/family problems	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Legal	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Stressors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Orientation/alertness/awareness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Supports	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Current medications (psychotropic and medical)			
Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Vitals					
Blood pressure	Temperature	Pulse	Respiratory	Blood alcohol level	UDS ☐ Yes ☐ No
If a urine drug screen (UDS) was conducted, please detail the outcome.					

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Previous treatment

Is the member currently in psychiatric or substance use treatment with any other treatment provider (Community Mental Health Centers [CMHC] or private physician) at the time of this admission? ☐ Yes ☐ No

Include documentation of what outpatient services are currently being provided and by whom. Include what other treatment may have been tried but failed and by whom. Request medical records from previous treatment providers.

Provider/organization name	Address	Phone No.	Contact person

Attachments for continued stay consideration:

1. History and physical with psychiatric evaluation
2. Psychosocial assessment
3. A detailed current treatment plan with medications, types of therapies, hours per day in treatment
4. Description of goals and how progress will be assessed
5. Lab work including any UDS results

Discharge information

Primary care physician (PCP)

Please fax a copy of the discharge summary to the member's PCP and behavioral health provider upon discharge.

Discharge plan	Expected discharge date

Planned discharge level of care: (Check all that apply.)

☐ Outpatient with current treatment provider	☐ Outpatient new referral
☐ Partial hospital/CMHC day treatment	☐ Intensive outpatient/CMHC rehab services
☐ Residential treatment (under the age of 21)	☐ Referral to substance abuse treatment provider
☐ Targeted case management with CMHC provider	☐ Other

Actual discharge date	Actual discharge level of care

Actual discharge receiving provider or facility

Prior authorization for next level of care (if required) obtained? ☐ Yes ☐ No ☐ No authorization required

All follow-up appointments must be within 7 days but no later than 14 days of discharge from inpatient level of care. It is the inpatient providers' responsibility (as part of their discharge planning process) to assure that the follow-up appointment has been made prior to discharge.

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Follow-up appointment information		
Provider name		
Appointment date	Appointment time	
Address	City, state	ZIP code
Comments		