Behavioral health continued stay request

Verify type of service requested

☐ Acute behavioral health ☐ Substance abuse detoxification ☐ Substance abuse rehabilitation ☐ Opioid treatment
☐ Inpatient trauma treatment (Active Duty Service Members require referral from the military hospital or clinic)
☐ Full day partial hospitalization program: # of units requested: _______ Days attended: _______ Hours of program: ______
☐ Half day partial hospitalization program: # of units requested: _______ Days attended: _______ Hours of program: ______
☐ Intensive outpatient program: # of units requested: _______ Days attended: _______ Hours of program: ______
☐ Psychological/Neuropsychological testing: # of units requested: _______ Dates of service start: _________ End: _________

Revenue code for type of service selected: ____

Services rendered via Telemedicine: ☐ Yes ☐ No

Note: Residential Treatment Center (RTC) referrals have their own initial and concurrent referral request forms separate from this document.

Beneficiary information

Name: ____

DOB: ______________________ Patient ID or sponsor SSN: ______________________

Address: ____

City: ______________________ State: __________ ZIP Code: __________

Other Health Insurance (OHI): ____

Rendering provider or place of service information

Name/Place of service: ____

Address: ____

Phone: ______________ Fax: ______________ Tax ID: ______________ NPI: ______________

Utilization Review (UR) contact/contact at provider location: ______________________

UR phone: ______________________ UR fax: ______________________

Attending MD: ______________________ MD phone: __________

Complete for trauma program for Active Duty Service Member only (please print legibly):

Military health facility name: ____

Referral management point of contact: ______________________ Phone: __________

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Supporting clinical documentation

DSM-5 diagnoses: (include diagnosis changes since admission and all comorbid medical conditions):

Medications (include any anticipated changes since admission, planned future medication changes and PRN medications):

Current clinical and progress in treatment:

Behavior on the unit/behavior in the program (agitation or aggression, participation in treatment, ability to perform activities of daily living, sleep, appetite, etc.):

Mental status exam:

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For Eating Disorder (ED), add the following information: weight changes since admission, current weight, Body Mass Index (BMI), ideal body weight, vital signs, abnormal labs, binging, purging, restricting, excessive exercise and any other clinically relevant information (if no ED leave this question blank):

For continued substance abuse treatment add target substance(s), vital signs, withdrawal symptoms, COWS/CIWA score and detox protocol, labs, the individual's stage of change, motivation for change, readiness for recovery and note the treatment focus; i.e., relapse prevention planning, ASAM, 12 step. (If no SUD leave this question blank):

Significant medical problems requiring intervention:

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Biopsychosocial situation (legal, living situation, family/support system involvement, work/school etc.):

Family therapy (required for children and adolescents):

Safety plan:

Barriers to discharge:

Discharge plan and estimated length of stay:

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Discharge review

Discharge date: ______________ Discharge diagnoses: ______________________________

Discharge planner name/number: ______________________________

Patient phone: ______________________________

For partial hospitalization and intensive outpatient, please provide number of sessions used: ______________

Discharge follow-up appointments including provider name, contact number, date/time (post -discharge follow up appointments should be within seven days of discharge):

Discharge medications:

Discharge disposition (discharged to home, group home, stepped down to lower/higher level of care, etc.):

Note: All individual providers and hospital-based providers can be searched using the beneficiary's home ZIP Code at **HumanaMilitary.com/FindCare**

Submit referral form online

Behavioral health requests should be submitted online when requesting an initial authorization or continued stay. To enroll for a self-service account, visit **HumanaMilitary.com**. Faxed forms are only accepted if the provider is unable to submit them electronically, and should be faxed to (877) 378-2316.

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