Behavioral health initial request form

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

Beneficiary information

Name: _____

DOB: _____ Patient ID or sponsor SSN: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Other Health Insurance (OHI): _____

Anticipated or actual date of service: _____ Anticipated length of service: _____

Referring/ordering provider information (Civilian referral)

Name/Specialty: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

TAX ID/NPI: _____ Phone: _____ Fax: _____

Military hospital or clinic referral (referral is necessary in order to approve for ADSM order entry number)

Military health facility name: _____

Referral management point of contact: _____

Phone: _____

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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: _____

Supporting clinical documentation

List all DSM-5 diagnoses (include comorbid medical conditions):

Medications:

Reason for admission – precipitating events and mitigating factors:

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Previous treatment history:

Mental status exam:

Biopsychosocial stressors:

Anticipated discharge plan (include services the person will receive post-discharge):

For Eating Disorder (ED), add the following information: height, 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):

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Complete this table for any substance use, substance abuse or substance dependence:

Name of substance	Length of use (years)	Age of first use	Date of last use	Amount and frequency of use

For Substance Abuse Treatment (SUD) treatment, add target substance(s), vital signs, withdrawal symptoms, COWS/CIWA score and detox protocol, 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 (complete this section if applicable to the person and/or service being requested):

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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