SUBSTANCE USE DISORDER CLINICAL REVIEW INFORMATION
Please fax to: Behavioral Health Services Toll-Free at 1.866.616.6255

Today's Date: _____ Information Submitted By: _____

REVIEW TYPE

☐ Initial ☐ Concurrent ☐ Discharge ☐ Level of Care Transfer

MEMBER INFORMATION

Patient's Name: _____ Date of Birth: _____

ID #: _____ PCP: _____

PROVIDER INFORMATION

Admitting Physician: _____ NPI: _____

Admitting Address: _____

Referring Physician: _____ NPI: _____

Referring Address: _____

UTILIZATION REVIEW CONTACT

Name: _____ Facility Name: _____

Facility NPI: _____ Address: _____

Date of Review: _____ Admission Date: _____ Time: _____

ADMISSION TYPE

☐ Emergent ☐ Elective ☐ Urgent ☐ Transfer ☐ Outpatient/Office

REQUESTED LEVEL OF CARE

☐ Early Intervention (0.5)

☐ Outpatient Services (1)

☐ Intensive Outpatient Services (2.1)

☐ Partial Hospitalization Services (2.5)

☐ Clinically Managed Low-Intensity Residential Services (3.1)

☐ Clinically Managed Population-Specific High Intensity Residential Services (3.3)

☐ Clinically Managed High-Intensity Residential Services (3.5)

☐ Medically Monitored Intensive Inpatient Services (3.7)

☐ Peer Recovery Support Service (H0038)

TheHealthPlan

ASSESSMENT
Clinical Disorders/Syndromes Diagnosis Codes: _____
Personality Disorders/Intellectual Disabilities Diagnosis Codes: _____
Suicidal Ideation: ☐ Ideation ☐ Plan ☐ Intent ☐ None
Homicidal Ideation: ☐ Ideation ☐ Plan ☐ Intent ☐ None
Admission Chief Complaint:

DIMENSION SEVERITY RATING
1. ACUTE INTOXICATION AND/OR WITHDRAWL POTENTIAL ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Summarize (acute/post-acute symptoms, pertinent lab/diagnostic results, etc.):
2. BIOMEDICAL CONDITIONS ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Summarize (relevant medical/physical issues, pertinent lab/diagnostic results, etc.):
3. EMOTIONAL/BEHAVIORAL CONDITIONS ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Summarize (acute psychiatric symptoms, psychiatric history, current psychotropic home meds, etc.):
4. READINESS TO CHANGE ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Summarize (admission circumstances, substance use disorder treatment history, etc.):
5. RELAPSE/CONTINUED USE POTENTIAL ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Summarize (precipitating factors, triggers, etc.):
6. RECOVERY ENVIRONMENT ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very Severe
Summarize (family/support components, educational needs, legal issues, etc.):

INITIAL ORDERS/TREATMENT

NUMBER OF DAYS OR SESSIONS PER WEEK: _____

ADHERENCE TO PROGRAM/DAYS ATTENDED IN THIS REVIEW PERIOD

CHANGES IN MEDICATION

DISCHARGE GOALS

BARRIERS TO DISCHARGE

DISCHARGE PLAN

Discharge Date: _____ ☐ Anticipated ☐ Actual

Follow-up Appointment Scheduled: _____

Discharge Address: _____ Phone:_____

New Level of Care (if applicable): _____