Behavioral Health Concurrent Review Form for Inpatient, RTC, PHP and IOP

Fill out completely to avoid delays. Once complete, submit via our website at **https://www.availity.com*** or fax this form to **1-844-462-0025**. If you have any questions, please contact us at **1-833-405-9086**.

Today's date:	
Contact information	
Level of care: ☐ Inpatient psychiatric ☐ Inpatient detoxification ☐ IOP mental health ☐ Inpatient psychiatric rehab ☐ PHP mental health ☐ IOP substance use disorder	
Member name:	
Member ID or reference #	Member DOB:
Member address:	
Member phone:	Hospital account #:
For child/adolescent, name of parent/guardian:	
Primary spoken language:	
Name of utilization review (UR) contact:	
UR phone:	UR fax:
Admit date:	☐ Voluntary ☐ Involuntary If voluntary, date of commitment:
Admitting facility name:	
Facility provider # or NPI:	
Attending physician (First and last name):	
Attending physician phone:	Provider # or NPI:
Facility unit:	Facility phone:
Discharge planner name:	
Discharge planner phone:	
Diagnosis (List all psychiatric, substance use disorders and medical.)	

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

BMOPEC-0085-20 August 2020

Risk of harm to self (within the last 24 to 48 hours)

If present, describe:

If prior attempt, date and description:

Risk rating (Check all that apply.):
☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Risk of harm to others (within the last 24 to 48 hours)

If present, describe:

If prior attempt, date and description:

Risk rating (Check all that apply.):
☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Psychosis (risk rating: 0 = None; 1 = Mild or mildly incapacitating; 2 = Moderate or moderately incapacitating; 3 = Severe or severely incapacitating; N/A = Not assessed)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
If present, describe:

Symptoms (Check all that apply.):
☐ Auditory/visual hallucinations ☐ Paranoia ☐ Delusions ☐ Command hallucinations

Substance use (risk rating: 0 = None; 1 = Mild or mildly incapacitating; 2 = Moderate or moderately incapacitating; 3 = Severe or severely incapacitating; N/A = Not assessed)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
If present, describe last use, frequency, duration, sober history:

Substance (Check all that apply.):
☐ Alcohol ☐ Marijuana ☐ Cocaine
☐ LSD ☐ Methamphetamines ☐ Opioids
☐ Barbiturates ☐ PCP ☐ Benzodiazepines
☐ Other (Describe.):

Urine drug screen: ☐ Yes ☐ No

Result (if applicable): ☐ Positive (If positive, list drugs.):
☐ Negative
☐ Pending

Current treatment plan

Medications

Have medications changed (type, dose/and/or frequency) since admission?
☐ Yes
☐ No
If yes, give medication, current amount and change date:

Have any PRN medications been administered?
☐ Yes
☐ No
If yes, give medication, administration date and current amount:

Member's participation in and response to treatment

Attending groups?
☐ Yes
☐ No
☐ N/A

Family or other supports involved in treatment?
☐ Yes
☐ No
☐ N/A

Adherent to medications as ordered?
☐ Yes
☐ No
☐ N/A

Member is improving in (Check all that apply.):

Thought processes	☐ Yes	☐ No
Affect	☐ Yes	☐ No
Mood	☐ Yes	☐ No
Performing ADLs	☐ Yes	☐ No
Impulse control/behavior	☐ Yes	☐ No
Sleep	☐ Yes	☐ No

Support system (Include coordination activities with referring providers, case managers, family, community agencies and providers who will see member after discharge. If case is open with another agency, name the agency, phone number and case number.)

Discharge plan (Note changes and barriers to discharge planning in these areas and plan for resolving barriers. If a recent readmission, indicate what is different about the plan from last time. Identify provider who will be following up with patient.)

Housing issues:

Psychiatry:
Therapy and/or counseling:
Medical:
Wraparound services:
Substance use services:
Planned discharge level of care:
Expected discharge date:
Submitted by:
Phone: