Healthy Blue

MO HealthNet Managed Care (Medicaid)

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

Fill out completely to avoid delays. Once complete, submit at **https://www.availity.com**.* 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.

Healthy Blue is a Medicaid product offered by Missouri Care, Inc., a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered statewide by Missouri Care, Inc. and administered in the Kansas City service region by Missouri Care, Inc. in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Inc. and Blue Cross and Blue Shield of Kansas City are both independent licensees of the Blue Cross and Blue Shield Association.

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Precipitant to admission (Be specific. Why is the treatment needed now?)

Risk of harm to self

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

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
Blood alcohol level:	☐ Yes ☐ No ☐ Unknown
Result (if applicable):	☐ Value: ☐ Pending
Substance use screening (Check if applicable and give score.):	☐ CIWA: ☐ COWS:

Previous treatment (Include provider name, facility name, medications, specific treatment/levels of care and adherence.)
Current treatment plan
Scheduled medications:
As-needed medications administered (not ordered):
Other treatment and/or interventions planned (including when family therapy is planned):
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.)
Results of depression screening
Readmission within last 30 days: ☐ Yes ☐ No If yes, and readmission was to the discharging facility, what part of the discharge plan did not work and why?
Initial discharge plan (List name and number of discharge planner, and include whether the member can return to current residence. Identify provider who will be following up with patient.)

Planned discharge level of care:
Describe any barriers to discharge:
Expected discharge date:
Submitted by:
Phone: