Behavioral Health Service Request Form

Prominence Health Plan

Fax form to: (888) 393-2348
UM Department Phone:
Local: 775-770-9350
Toll free: 1-844-894-8086
PLEASE TYPE or WRITE LEGIBLY
or request will be returned as unable to process

MEMBER INFORMATION

Member Name:	DOB:
Member ID:	Address:

PROVIDER INFORMATION

Provider Group/Clinic:	Contact Name:
Phone:	Fax:
Street Address:	City | State | Zip:
Provider ID/NPI:	
REQUEST START DATE FOR THIS AUTHORIZATION:	
Date of first visit for this episode of care:	
Estimated # visits needed to meet tx goals:	

MENTAL HEALTH AND/OR SUBSTANCE ABUSE HISTORY

(Including alcohol, drugs, and prescription medication)

☐ **Yes** ☐ **No** Previous substance abuse treatment inpatient/outpatient? If yes, complete the following:

Level of care:	**Dates Tx:**
Level of care:	**Dates Tx:**
Level of care:	**Dates Tx:**

☐ **Yes** ☐ **No** Drug/alcohol use (in past 12 months)? If **YES,** complete the following:

Substance	Amount	Frequency	Age Began	Last Used

DIAGNOSIS

(Code and Description of primary and applicable co-occurring diagnoses)

1.

2.

3.

Psychosocial Stressors:

MEDICATION

Please list medication(s), dosage and frequency below. ○ Not applicable

Name	Dosage	Frequency

Prominence Health Plan

GOALS
(Please attach additional goals and information, as needed)

DESCRIPTION OF GOALS:

Progress:

Goal Status: ☐ Accomplished & removed ☐ Continue ☐ Additional progress needed ☐ Revised – new goal/objective

CLINICAL ASSESSMENT: CURRENT SIGNS/SYMPTOMS
(please check box if currently present)

☐	Generalized anxiety	☐	Pressured Speech	☐	Loose Associations
☐	Depressed Mood	☐	Weight Loss/Gain	☐	Psychomotor Retardation
☐	Appetite Disturbance	☐	Panic Attacks	☐	Concentration/Attention Problems
☐	Sleep Disturbance	☐	Phobias	☐	Impulse control problems
☐	Low Energy	☐	Obsessions/Compulsions	☐	Conduct problems
☐	Agitation	☐	Circumstantial/Tangential	☐	Oppositional behaviors
☐	Labile	☐	Sexual Dysfunction	☐	Acute Stress Disorder
☐	Irritability	☐	Paranoid Ideation	☐	Other:

MENTAL STATUS

☐	Oriented x3	☐	Impaired Memory	☐	Delusions- Type:
☐	Impaired Judgment	☐	Other Cognitive Impairment	☐	Hallucinations- Type:

RISK ASSESSMENT
(Please check NO if not present- if checked, please provide additional information)

☐ NO	SUICIDAL RISK:	☐ NO	HOMICIDAL RISK:	☐ NO	ABUSE RISK:
☐	Ideation	☐	Ideation	☐	Verbal
☐	Intent	☐	Intent	☐	Emotional
☐	Plan	☐	Plan	☐	Physical
☐	Means	☐	Means	☐	Sexual
☐	Attempt	☐	Attempt	☐	History
☐	History	☐	History		

REQUESTED CODES and SERVICE TYPE

Service Type (select MH or SUD):	Mental Health	○		Substance Use	○

Code		Frequency of service	Code		Frequency of service
○	Structured Intensive Outpatient (IOP) Program	___ x per week	○	Partial Hospitalization (PHP)	___ x per week
○	Residential Treatment (sub-acute)		○	90870- Outpatient Electroconvulsive Treatment (ECT)	Weekly ○ Monthly ○ Other: ○
○	Other Codes and Description:		○	Other Codes and Description:	

SIGNATURE

Reviewer Name (print):

Signature/Credential: **Date:**