AmeriHealth Caritas
District of Columbia

Behavioral Health Fax Form

Today's date: **Start date of admission or service:**

Type of review	Type of admission		Admission status	Estimated length of stay
☐ Precertification ☐ Continued stay ☐ Discharge	☐ Intensive outpatient ☐ Mental health inpatient ☐ Partial hospitalization/day treatment	☐ Substance use ☐ Detox ☐ Rehab	☐ Voluntary commitment ☐ Involuntary commitment	___________ (days/units) **Readmission within 30 days?** ☐ Yes ☐ No

Member information	
Member name (last, first, middle initial):	
Eligibility ID number:	Date of birth:
Member address:	
Emergency contact (other than primary caregiver):	Phone:
Legal guardian or parent:	Phone:

Provider information	
Facility or provider name:	NPI number or tax ID:
Attending M.D.:	Provider ID:
Facility or provider address:	
Utilization Management review contact:	Phone:
DSM-5 diagnoses (include mental health, substance use, and medical):	

Medications

Medication name	Dosage	Frequency	Date of last change	Type of change
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
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				☐ Increase ☐ Decrease ☐ D/C ☐ New
Additional information:				

Presenting problem or current clinical update (Include suicidal ideation, homicidal ideation, psychosis, mood/affect, sleep, appetite, withdrawal symptoms, chronic substance use.)

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Eligibility ID number: _____

Treatment history and current treatment participation
Previous mental health or substance use inpatient, rehab, or detox:
Outpatient treatment history:
Is the member attending therapy and groups? ☐ Yes ☐ No If yes, please specify:
Explain clinical treatment plan:
Family involvement and/or support system:

Substance use: ☐ Yes ☐ No
If yes, mental health services only, please explain how substance use is being treated:
If yes, please complete below for current American Society of Addiction Medicine (ASAM) dimensions and/or submit with documentation for substance use, intensive outpatient, partial hospitalization/day treatment, substance use detox, and substance use rehab.

Dimension rating (0 – 4)	Current ASAM dimensions are required			
Dimension 1: Acute intoxication and/or withdrawal potential Ranking:	Substances used (pattern, route, last used):	Tox screen completed? ☐ Yes ☐ No If yes, results:	History of withdrawal symptoms:	Current withdrawal symptoms:
Dimension 2: Biomedical conditions and complications Ranking:	Vital signs:	Is member under doctor care? ☐ Yes ☐ No Current medical conditions:	History of seizures? ☐ Yes ☐ No	
Dimension 3: Emotional, behavioral, or cognitive conditions and complications Ranking:	Mental health diagnosis:	Cognitive limits? ☐ Yes ☐ No	Psych medications and dosages:	Current risk factors (e.g., suicidal ideation, homicidal ideation, psychotic symptoms):
Dimension 4: Readiness to change Ranking:	Awareness/commitment to change:	Internal or external motivation:	Stage of change, if known:	Legal problems/ probation officer:
Dimension 5: Relapse, continued use or continued problem potential Ranking:	Relapse prevention skills:	Current assessed relapse risk level: ☐ High ☐ Moderate ☐ Low	Longest period of sobriety:	
Dimension 6: Recovery/living environment Ranking:	Living situations:	Sober support system:	Attendance at support group:	Issues that impede recovery:

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Discharge planning	
Discharge planner name:	Discharge planner phone:
Residence address upon discharge:	
Treatment setting upon discharge:	Treatment provider upon discharge:
Has a post-discharge seven-day follow-up appointment been scheduled? ☐ Yes ☐ No	
If no, please explain:	
If yes, give treatment provider name and date and time of scheduled follow-up:	

When form is complete, please fax to **1-855-410-6638**.