

Instructions

- Complete this form in its entirety.
- Separate fax forms are required for each member and each request.
- You will receive a Notice of Coverage when approved, or contacted via phone if a peer-to-peer review is needed, within 24 hours (excluding weekends and holidays).
- If for some reason you do not receive a determination within 24 hours, call 1-866-595-8133.
- Once the member is discharged and no additional days are needed, fax the discharge to 1-866-698-6341 within 24 hours.

Submit by fax to:

1-866-698-6341

Retain a copy of the fax confirmation for your records.

Review Information

Date: _____

UR Name: _____

UR Phone: _____

Provider Name: _____

UR Fax: _____

ASAM LOC: _____

Provider NPI: _____

Member Information

Full Name: _____

Age group: Adult (21 and older)
 Adolescent (under 21)

Medicaid ID: _____

Employment: _____

Birth Date: _____

Admit Date: _____

Clinical Information

DIM 1: (Acute intoxication and or withdrawal) _____

Vitals: _____

DIM 2: (Biomedical conditions) _____

DIM 3: (Readiness to change) _____

Drug of choice (include drug, amount, frequency, 1st use and last use): _____

Sober Supports: _____

Sober Time: _____

Why Now (current motivation): _____

Date and Results of Urine Drug Screen:

CIWA/COWS:

Goals/Treatment Plan:

Goals That Have Been Completed (If This Is A Concurrent Review):

Medications

Name	Dose/Frequency	Initiation
		<input type="checkbox"/> Prescribed prior to admission <input type="checkbox"/> Initiated during this admission
		<input type="checkbox"/> Prescribed prior to admission <input type="checkbox"/> Initiated during this admission
		<input type="checkbox"/> Prescribed prior to admission <input type="checkbox"/> Initiated during this admission
		<input type="checkbox"/> Prescribed prior to admission <input type="checkbox"/> Initiated during this admission
		<input type="checkbox"/> Prescribed prior to admission <input type="checkbox"/> Initiated during this admission
		<input type="checkbox"/> Prescribed prior to admission <input type="checkbox"/> Initiated during this admission

Discharge Planning

Discharge Plan:

Any barriers to successful discharge:

CSoC Screening

Eligibility

Is member between ages 5-20? (If "No", skip the remaining CSoC Screening questions.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
DSM-V diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently receiving FFT, MST, or Homebuilders?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Appropriateness

Has the child ever talked about or actually tried to hurt him/herself or acted in a way that might be dangerous to him/her?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the child ever been a danger to others (e.g. threatening to kill or seriously injure another person, fighting to the point of serious injury, been accused of being sexually aggressive, or engaging in fire setting)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Has the child deliberately or purposefully behaved in a way that has gotten him/her in trouble with the authorities such as breaking the rules at school or laws in your community?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

If Sent to Physician Advisor Review for Not Meeting Medical Necessity

- By notes only**
- Peer to Peer** (complete below)

Attending Physician: _____

Phone number: _____ Best time to call: _____