AmeriHealth Caritas Florida

Behavioral Health Fax Form

Mental Health & Substance Use Treatment — Higher Levels of Care

When complete, please fax to **1-855-236-9293**.

Today's date: _____ Start date of admission/service: _____

Type of review	**Type of admission**	**Admission status**	**Estimated length of stay:**
☐ Precertification	☐ MH-IP ☐ Substance abuse:	☐ Voluntary commitment	(days/units)
☐ Continued stay	☐ PHP/Day treatment ☐ Detox	☐ Involuntary commitment	**Re-admission within 30 days?**
☐ Discharge	☐ IOP-SA ☐ Rehab		☐ Yes ☐ No

Member information

Member name (Last, First, MI)	
Medicaid ID #	Date of birth
Member address	Phone
Emergency contact (other than primary caregiver)	Phone
Legal guardian/parent	Phone

Provider information

Facility/Provider name	NPI #/Tax ID
Attending MD	Provider ID
Facility/Provider address	
UM review contact	Phone
DSM-5 Diagnoses (include mental health, substance abuse & medical)	

Medications

Medication name	Dosage	Frequency	Date of last change	Type of change
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
Additional information				

Presenting problem/current clinical update (Include SI, HI, psychotic, mood/affect, sleep, appetite, withdrawal symptoms, chronic SA)

Page 2 of 2 for member name: _____ Medicaid ID number: _____

Treatment history and current treatment participation

Previous MH/SA 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 abuse: ☐ Yes ☐ No

If yes, MH services only, please explain how substance abuse is being treated:
If yes, please complete below for current ASAM dimensions and/or submit with documentation for SA IOP, PHP/Day Treatment, SA Detox and SA 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:	MH diagnosis:	Cognitive limits? ☐ Yes ☐ No	Psych medications and dosages:	Current risk factors (SI, HI, psychotic symptoms, etc.):
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:

Discharge planning

Discharge planner name:	Discharge planner phone:
Residence address upon discharge:	
Treatment setting upon discharge:	Treatment provider upon discharge:
Has a post-discharge 7-day follow-up appointment been scheduled? ☐ Yes ☐ No	

ICD-10 discharge diagnoses (psychiatric, chemical dependency, and medical):	
Was this discharge against medical advice (AMA)?	☐ Yes ☐ No
Was discharge information sent to the primary care provider (PCP)/psychiatrist?	☐ Yes ☐ No
Was discharge plan discussed with member?	☐ Yes ☐ No
If required for a minor or dependent adult, was informed consent for psychotherapeutic medication completed and given to parent/guardian?	☐ Yes ☐ No
Complete discharge diagnoses (include mental health, substance abuse & medical):	

Aftercare appointment 1 (must be within seven days)	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:
Is aftercare appointment scheduled within seven calendar days? ☐ Yes ☐ No If not, please explain below:	
If any identified barriers to discharge, please explain:	

Aftercare appointment 2	
Provider name (clinician and facility):	Provider contact number:
Date of appointment:	Time of appointment:

Any other providers involved in the aftercare plan: Please list below with contact information.	
Form submitted by:	

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