Connecticut BHP
Supporting Health and Recovery

RETROACTIVE ELIGIBILITY REVIEW TEMPLATE – WEB REGISTERED SERVICES

PLEASE COMPLETE AND FAX TO: 1-(866)-434-7681

ALL FIELDS WITH AN * ARE REQUIRED

Provider EDS/CMAP ID # (Medicaid 9-digit ID): _____

Name of clinician who filled out this form: _____ **Credentials/Title**: _____

Facility/Provider Name: _____ **Contact # & Ext:** _____

Facility/Provider Service Location: _____

Member Name: _____

Medicaid/Consumer ID#: _____ **DOB:** _____ **and/or SSN:** _____

***LEVEL OF CARE:** ☐ **Intensive Outpatient** ☐ **EDT** ☐ **Outpatient** ☐ **Methadone Maintenance** ☐ **Ambulatory Detoxification** ☐ **Home Based Services** ☐ **MDFT** ☐ **MST** ☐ **FFT** ☐ **IICAPS (excluding CSSD IICAPS)**

***TYPE OF SERVICE:** ☐ **Mental Health** ☐ **Substance Abuse**

***PROVIDER TYPE:** ☐ **Comm Mntl Hlth Ctr** ☐ **Ind Clinic** ☐ **FQHC** ☐ **O/P Hospital** ☐ **Office** ☐ **Psych Facility – Partial Hosp**

QUESTIONS: (** signifies a required field)*

1. *** Requested start date** (EX: 09/01/2010): _____
2. * **Total number of units requested:** _____
3. * **Requested end date of authorization:** _____
4. *** Is member still in treatment?** ☐ **Yes** ☐ **No**
5. **Behavioral Diagnoses (*Primary is required)***

   ***Diagnosis Code:** _____ ***Description**_____

   ***Diagnostic Category:** _____

   Diagnosis Code: _____ **Description**_____

   Diagnostic Category: _____

6. **Primary Medical Diagnoses (Primary is required or indicate "None" or "Unknown")**

   ***Diagnosis Code:** _____ ***Description**_____

   ***Diagnostic Category:** _____

   Diagnosis Code: _____ **Description**_____

   Diagnostic Category: _____

7. *Social Elements Impacting Diagnoses (Required - Check all that apply)

☐ None ☐ Educational problems ☐ Financial problems ☐ Housing problems (Not Homelessness)

☐ Occupational problems ☐ Other psychosocial and environmental problems _____

☐ Problems with access to health care services ☐ Homelessness

☐ Problems related to interaction with legal system / crime ☐ Problems with primary support group

☐ Problems related to social environment ☐ Unknown

8. Functional Assessment *(optional)*

☐ CDC- HRQOL ☐ CGAS ☐ FAST ☐ GAF ☐ OMFAQ ☐ SF12 ☐ SF36 ☐ WHO DAS

☐ OTHER _____ ASSESSMENT SCORE_____

9. Current Risks

Key: 0 = None 1 = Mild or Mildly Incapacitating 2 = Moderate or Moderately Incapacitating 3 = Severe or Severely Incapacitating N/A = Not Assessed

A. *Members Risk to Self 0 ☐ 1 ☐ 2 ☐ 3 ☐ ☐ N/A

B. *Members Risk to Others 0 ☐ 1 ☐ 2 ☐ 3 ☐ ☐ N/A

10. Current Impairments

A. *Mood Disturbances (Depression or Mania)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

B. *Weight Changes Associated with Behavioral Diagnosis

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

For 2 or 3 rating:

Weight ☐ Gain ☐ Loss ☐ N/A

Past 3 mos_____Lbs ☐ N/A

Current Wt_____Lbs ☐ N/A

Height_____Ft_____In ☐ N/A

C. *Anxiety

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

D. *Psychosis / Hallucinations / Delusions

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

E. *Medical / Physical Conditions

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

F. *Thinking/Cognitive/Memory/Concentration Problems

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

G. *Substance Abuse / Dependence

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

For 2 or 3 rating: Check all that apply

☐ Alcohol Illegal ☐ Drugs ☐Prescription Drugs

H. *Impulsive/Reckless/Aggressive Behavior

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

I. *Job/School/Performance Problems

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

J. *Activities of Daily Living Problems

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

K. *Social Functioning/Relationships/Marital/Family Problems

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

L. *Impairments Related to Loss/Trauma

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

M. *Legal

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

For 1, 2 or 3 rating: Check all that apply

☐ Juv Jus ☐ Probation ☐ Parole ☐ Other Court

Treatment Plan

11. *Is psychiatric medication evaluation or medication management visit indicated? ☐ Yes ☐ No

12. *Do family members or sig. others actively participate in the members treatment or recovery? ☐ Yes ☐ No

If yes, are any of the family members/significant others receiving their own MH or SA treatment? ☐ Yes ☐ No

13. *Treatment plan was developed with member (or guardian) and has measurable time limited goals. ☐ Yes ☐ No

14. *Does a documented goal oriented treatment plan exist? ☐Yes ☐ No

15. *Anticipated / Target Date for achievement of current treatment plan goals _____

Discharge Information *(if applicable)*

16. Anticipated Discharge date (EX: 09/01/2010)**:** _____

17. *Actual* Discharge date (EX: 09/01/2010)**:** _____

18. *Type of Discharge ☐ AMA ☐ Planned

19. *Actual Level of Care/Service Discharge To (primary)

☐ Community Support Team ☐ Outpatient ☐ Targeted Case Management ☐ Inpatient ☐ 23 Hour ☐ CSU ☐ PHP ☐ RTC ☐ Group Home ☐ Halfway House ☐ Day Services ☐ IOP/SOP ☐ Alternative ☐ Community Support ☐ Day Treatment ☐ Foster Care ☐ In-Home & Family Services ☐ Placement Services ☐ PRTF ☐ Residential Child Care ☐ Respite ☐ Specialty Children's Programs ☐ Subacute ☐ Other ☐ Assertive Community Treatment ☐ Facility Based Crisis ☐ Intensive In-Home ☐ MST ☐ NCMC Only Ambulatory Detox ☐ NCMC Only Medically Supervised ADATC ☐ NCMC Only Non-Hospital Med Detox. ☐ NCMC Only SA Med Monitored Resi ☐ NCMC Only SA Non Med Resi Over 21 ☐ Opioid Treatment ☐ Psychosocial Rehab ☐ SACOT

20. *Name of Discharge Provider _____

21. *Date of Follow-Up - Contact Date (EX: 09/01/2010)**:** _____

ADDITIONAL REQUIRED QUESTIONS *ONLY* FOR METHADONE MAINTENANCE/AMBULATORY DETOX:

Methadone Maintenance

*** Is the member currently maintained on Methadone?** ☐ YES ☐ NO

a. **If yes**, how long has the member received Methadone services?

☐ 6 mos or less ☐ 7 mos – 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs >

b. **If no**, what has been the duration of the member's opioid use?

☐ Less than 1 yr ☐ 1-3 yrs ☐ 3-5 yrs ☐ 5 yrs or >

***What other services are included in the treatment plan?**

☐ Community Support (AA/NA) ☐ IOP/PHP ☐ Other Behavioral Health Services ☐ Outpatient Therapy ☐ PCP / MD Follow-up

***What is the ultimate treatment goal?** ☐ Abstinence ☐ Methadone Maintenance

Ambulatory Detox

***From what substance is the member in need of detoxification? (select all that apply)**

☐ Alcohol ☐ Benzodiazepines ☐ Opiates

***Has the member had a previous detox in any setting in the past year?**

☐ YES ☐ NO

If yes, number of detoxes in the past year?

☐ **1** ☐ **2** ☐ **3** ☐ **4+**

***What is the identified discharge plan? (Select all that apply)**

☐Community Support (AA/NA) ☐ IOP/PHP ☐ Methadone Services ☐ Other Behavioral Health Services ☐ Outpatient Therapy ☐ PCP/MD Follow-up