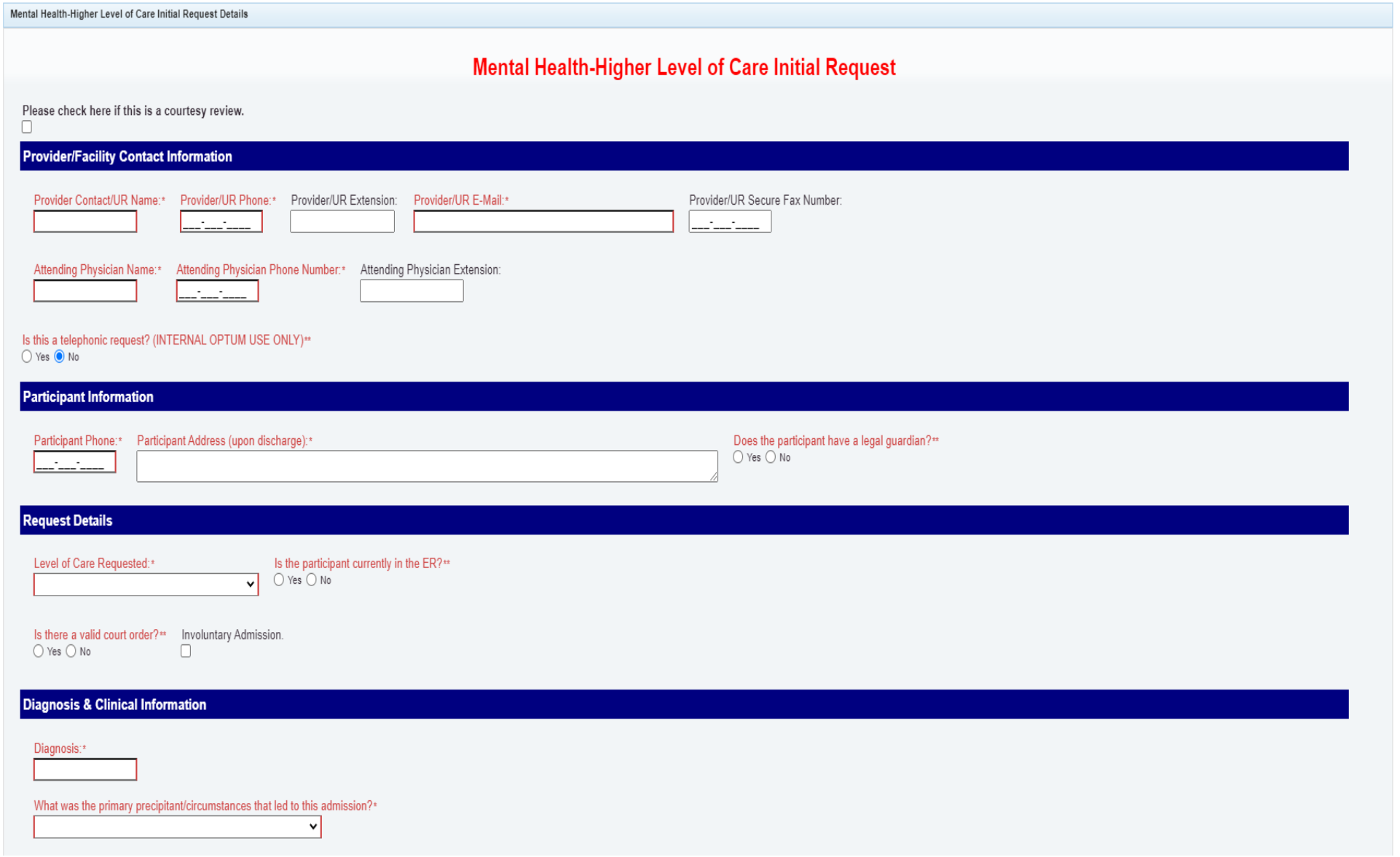
Mental Health-Higher Level of Care Initial Request



Mental Health-Higher Level of Care Initial Request Details

Mental Health-Higher Level of Care Initial Request

Please check here if this is a courtesy review.

☐

Provider/Facility Contact Information

Provider Contact/UR Name:* | Provider/UR Phone:* | Provider/UR Extension: | Provider/UR E-Mail:* | Provider/UR Secure Fax Number:

Attending Physician Name:* | Attending Physician Phone Number:* | Attending Physician Extension:

Is this a telephonic request? (INTERNAL OPTUM USE ONLY)**

○ Yes ◉ No

Participant Information

Participant Phone:* | Participant Address (upon discharge):* | Does the participant have a legal guardian?**

○ Yes ○ No

Request Details

Level of Care Requested:* | Is the participant currently in the ER?**

○ Yes ○ No

Is there a valid court order?** | Involuntary Admission.

○ Yes ○ No ☐

Diagnosis & Clinical Information

Diagnosis:*

What was the primary precipitant/circumstances that led to this admission?*

Provide additional detail about the specific event leading to this treatment episode:*

What current symptoms, risks or impairments require treatment under the requested level of care? Please include current clinical presentation.*

Any additional psychiatric diagnoses impacting current treatment?**
Yes No

Was substance use a contributing reason for this admission?**
Yes No

Are there any active medical conditions?**
Yes No

Is participant pregnant?**
Yes No

Was the participant admitted with either of the following diagnoses:

Cognition Diagnosis and/or age 65+?**
Yes No

Eating Disorder Diagnosis?**
Yes No

Medications

Current Medications (include dosage and frequency):*

Are there any barriers/issues related to the medication regimen?**
Yes No

Recovery/Discharge Plan

What specific actions or treatment are planned to address the acute symptoms or behaviors?*

Facility planned discharge level of care:*

Estimated length of stay (ELOS):*

Discharge Plan:*

Barriers to discharge and plans to address them to promote sustained recovery:*

Any relevant information not otherwise discussed that is important to the review of this case.

Confirmation & Attestation

Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.

I attest all of the information provided is accurate and reflected in the participant's medical record.*

Important:

1) When this form is saved a pop-up box will appear regarding an additional form being recommended.

2) Click Continue to move to the next form, DO NOT click Decline.

3) Do NOT click Cancel or the "X" on the top right of the screen before completing the Data Capture form.

4) After completing the Data Capture form, click Save and you will be returned to the authorization screen.

Data Capture Required:

Yes