Anthem BlueCross

Cal MediConnect Plan

Behavioral Health Initial Review Form

This form is for inpatient, residential treatment and partial hospitalization program (PHP) or intensive outpatient program (IOP) services.

Please submit via the provider website at **https://mediproviders.anthem.com/CA** or fax to **1-877-434-7578**.

Today's date:		
Contact information		
Level of care Inpatient psych ☐ Inpatient detox ☐ Inpatient chemical dependency ☐ Psychiatric RTC ☐ Chemical dependency RTC ☐ PHP ☐ IOP ☐		
Member name:	Member ID or reference #:	Member DOB:
Member address:		Member phone #:
Hospital account #:	For child/adolescent, name of parent/guardian:	Primary spoken language:
Name of utilization review contact:	Utilization review contact phone #: Utilization review fax #:	
Admit date:	Level of care:	Voluntary or involuntary? (If involuntary, attach copy of court order — PEC, etc., as applicable.)
Facility name:	Facility NPI or Anthem Blue Cross (Anthem) provider #:	
Attending physician first and last names:	Attending physician phone #:	
Provider NPI or Anthem provider #:	Facility unit:	Facility phone #:
Discharge planner name:	Discharge planner phone #:	
ICD-10 diagnoses		

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Precipitant to admission — Be specific. Why is the treatment needed now?
Risk assessment — Include medical necessity reasons for admission.
Current legal issues
Substance abuse or dependence — Include current UA/lab results and use pattern (substances, last use, frequency, duration, sober history and vitals).

Current assessment of American Society of Addiction Medicine (ASAM) — For substance use disorders, please complete the following additional information.

Dimension (describe or give symptoms)	**Risk rating**
Dimension 1 (acute intoxication and/or withdrawal potential — include vitals and withdrawal symptoms): _____ _____	Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe ☐
Dimension 2 (biomedical conditions and complications): _____ _____	Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe ☐
Dimension 3 (emotional, behavioral or cognitive complications): _____ _____	Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe ☐
Dimension 4 (readiness to change): _____ _____	Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe ☐

Dimension 5 (relapse, continued use or continued problem potential): _____ _____	Minimal/none	☐	Mild ☐	Moderate ☐	
	Significant	☐	Severe ☐		
Dimension 6 (recovery living environment): _____ _____	Minimal/none	☐	Mild ☐	Moderate ☐	
	Significant	☐	Severe ☐		

If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?
Co-occurring medical/physical illness
Functional impairment/strength (including interpersonal relations, personal hygiene and work/school)
Recovery environment — Describe level of stress including support system.
Engagement/level of active participation in treatment (past and present)
Previous treatment — Include provider name, facility name, medications, specific treatment/levels of care and adherence.
Current treatment plan
Standing medications:
As-needed medications administered (not ordered):
Other treatment and/or interventions planned (including when family therapy is planned):
Coordination of care — Include coordination activities with case managers, family, community agencies, etc. If case is open with another agency, name the agency, phone and case number

Readmission within last 30 days?	
Yes ☐ **No** ☐ If **yes** and readmission was to the discharging facility, what part of the discharge plan did not work and why?	
Initial discharge plan — List name and number of discharge planner and include whether the member can return to current residence.	
If applicable, please attach summary sheets of LOCUS, CASII or other assessments that may support your request.	
Expected length of stay from today:	
Submitted by:	**Phone:**