Colorado Community Health Alliance (CCHA) | Health First Colorado (Colorado's Medicaid Program)

Behavioral Health Initial Review Form for Mental Health Inpatient, ATU, CSU, Adult RTC, PHP, and IOP

Submit your request electronically through our preferred method at **https://Availity.com**.

Note: This form serves as a general template to help care providers when requesting authorization and should be **completed in its entirety**. Please attach any necessary clinical documentation that could further explain the need for the requested level of care. Not doing so may result in processing delays. For additional information on medical necessity determinations and standard clinical documentation, see the Behavioral Health Provider Manual on **our website**.

Today's date:		
Contact Information		
Level of care: ☐ Inpatient psychiatric ☐ PHP mental health ☐ IOP mental health ☐ ATU ☐ CSU ☐ Adult Residential* *Procedure code and modifier required: • Procedure Code(s) requested: • Modifier(s) requested:		
Member ID:	Member DOB:	
Member address:		
Member phone:		
Primary spoken language:		
Admit date:		
Admitting facility name:	Facility NPI:	Facility TIN:
Facility address (where treatment will occur):		
Facility phone number:		
Attending physician/provider (first and last name):	Provider NPI:	Provider TIN:
Name of utilization review (UR) contact:		
UR contact phone number and/or email address:	UR contact fax number:	
Diagnosis (Psychiatric, Chemical Dependency, and Medical)		
Precipitant to Admission (Be specific. Why is the treatment needed now?)		
Risk of Harm to Self		

If present, describe:

If prior attempt, date, and description:

Risk rating (select all that apply):

☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Risk of Harm to Others

If present, describe:

If prior attempt, date, and description:

Risk rating (select all that apply):

☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Psychosis

Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

If present, describe:

Symptoms (select all that apply):

☐ Auditory/visual hallucinations ☐ Paranoia

☐ Delusions ☐ Command hallucination

Substance Use

Substance use risk rating: (0 = None; 1 = Mild or Mildly Incapacitating; 2 = Moderate or Moderately Incapacitating; 3 = Severe or Severely Incapacitating; N/A = Not Assessed)	**Substance** (mark all that apply)	
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	If present, describe last use, frequency, duration, sober history:	☐ Alcohol ☐ PCP ☐ Methamphetamines ☐ Marijuana ☐ LSD ☐ Benzodiazepines ☐ Cocaine ☐ Opioids ☐ Barbiturates ☐ Other (describe)

Urine drug screen: ☐ Yes ☐ No ☐ Unknown

Results (if applicable):

☐ Positive (If selected, list drugs.): ☐ Negative ☐ Pending

BAL: ☐ Yes ☐ No ☐ Unknown

Result (if applicable): ☐ Value: ☐ Pending

Substance use screening (Select if applicable and give score.):

☐ CIWA: ☐ COWS:

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 family therapy):

Support System **Include coordination activities with case managers, family, community agencies, and so on. If the case is open with another agency, name the agency, phone number, and case number.**
Initial Discharge Plan **List the name and number of the discharge planner and include whether the member can return to their current residence.**
Planned discharge level of care:
Describe any barriers to discharge:
Expected discharge date:
Submitted by:
Phone:

Disclaimer: Authorization indicates that Colorado Community Health Alliance determined medical necessity has been met for the requested service(s), but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.

If unable to submit this form via Availity Essentials, you may fax it to **1-844-452-8067**.