Behavioral Health Initial Review Form

Please fax this form to **1-877-434-7578** within two hours of admission.

Today's date:		
Level of care: ☐ Inpatient psych ☐ Inpatient detox ☐ Inpatient chemical dependency ☐ Psychiatric RTC ☐ Chemical dependency RTC ☐ PHP ☐ IOP		
Contact information		
Member name:		
Member ID or reference #:	Member DOB:	Member phone #:
Member address:		
Hospital account #:	For child/adolescent, name of parent/guardian:	Primary spoken language:
Name of utilization review (UR) contact:	UR phone #:	
Admit date:	UR fax #:	
☐ Voluntary ☐ Involuntary If involuntary, date of commitment:		
Admitting facility name:	Facility provider # or NPI:	
Attending physician (first and last names):	Attending physician phone #:	
Provider # or NPI:	Facility unit:	Facility phone #:
Discharge planner name:	Discharge planner phone #:	
Diagnoses (psychiatric, chemical dependency and medical)		
Precipitant to admission Be specific; why is the treatment needed now?		
Risk assessment Include medically necessary reasons for admission.		

Empire BlueCross BlueShield HealthPlus is the trade name of HealthPlus HP, LLC, an independent licensee of the Blue Cross and Blue Shield Association.

NYEPEC-1993-19 December 2019

Current legal issues
Substance use or dependence Current UA/lab results and use pattern (substances, last use, frequency, duration, sobriety history, vitals)

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):	
Support system Include coordination activities with case managers, family, community agencies, etc. If case is open with another agency, name the agency, phone number and case number.	
Results of depression screening?	
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 # of discharge planner and include whether the member can return to current residence.	
Days requested or expected length of stay from today:	
Submitted by:	**Phone #:**