Humana
Healthy Horizons™ in South Carolina

Healthy Connections

Inpatient, Sub-acute and CSU Services

Please complete form in its entirety and return to:
Email: CorporateMedicaidCIT@humana.com
Fax: **833-441-0950**

Behavioral Health Service Request Form

☐ Retro Request	Please indicate if the services are completed and the member is no longer in active Inpatient care. Please submit the member record for review.
Level of Care:	☐ Inpatient ☐ Sub-acute ☐ CSU
Place of Service:	☐ Inpatient Hospital ☐ Inpatient Psychiatric Hospital ☐ Community Mental Health Center

Please contact Humana for prior authorization of Inpatient services at the time of admission or on the next business day following admission to a psychiatric Inpatient program. After the initial authorization determination, providers will be required to perform concurrent review for any additional Inpatient days authorized. This form should be used by providers to ensure our review process will be as quick and efficient as possible.

Member Information

Last Name	First Name	Date of Birth	
Phone Number	Humana ID#	Gender ☐ Male ☐ Female	
Third Party Insurance ☐ Yes ☐ No	If yes, please attach a copy of the insurance card or provide the name and contact information of the insurer.	Language Spoken	

Treating Provider/Practitioner Information

Last Name	First Name	NPI	
Humana ID#	Participating ☐ Yes ☐ No	Discipline/ Specialty	
Street Address	City, State	Zip	
Phone Number	Fax Number	Office Contact	

Facility/Agency Information

Name	Facility ID	NPI	
Street Address	City, State	Zip	
Phone Number	Fax Number	Office Contact	

Service Type Requested	REV/HCPCS Code(S)	
Service Type		
Detox		
Rehab		
Service Request Start Date:	Projected Length of Stay:	Original Admission Date: (if different from Start Date Requested)
Transition of Care ☐ Yes ☐ No		Continuation of Care ☐ Yes ☐ No

Disclaimer: An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

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Humana Healthy Horizons in South Carolina is a Medicaid Product of Humana Benefit Plan of South Carolina, Inc.

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Diagnosis - Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	

Are services requested court ordered? ☐ **Yes** ☐ **No**
If **yes**, please submit a copy of the court order and all supporting documentation

Current CIWA Score: (if applicable)	COW Score: (if applicable)	Current ASAM Dimension Scores: (if applicable)

Reason for Admission

Presenting problem to be addressed by treatment plan:

Date problem began	Duration	Is member under the care of a psychiatrist	☐ Yes ☐ No

Is member currently inpatient? ☐ **Yes** ☐ **No**

If **yes**, what facility is member admitted and what is the current length of stay?

Is member currently receiving Outpatient services? ☐ **Yes** ☐ **No**

If **Yes**:

Name of Provider / Facility	Dates	Compliant
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**

_____ **I acknowledge that I am required to send a report of the member's admission to inpatient services to their PCP, and I will update their PCP quarterly.** (Initial)

Current Risk

Risk level scale: **0** = None; **1** = Mild, ideation only; **2** = Moderate, ideation with either a plan or history of attempts; **3** = Severe, ideation **AND** plan, with either intent or means.

Check the risk level for each category and check all boxes that apply.

Risk of self (SI)	☐ 0 ☐ 1 ☐ 2 ☐ 3	with	☐ Ideation ☐ Intent ☐ Plan ☐ Means
Risk of others (HI)	☐ 0 ☐ 1 ☐ 2 ☐ 3	with	☐ Ideation ☐ Intent ☐ Plan ☐ Means

Current serious attempt or non-suicidal self injury ☐ Yes ☐ No If **yes**, describe below. Check: ☐ SI ☐ HI

If above checked yes, please describe :

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Current Impairments	
Scale: **0** = None; **1** = Mild; **2** = Moderate; **3** = severe; **N/A** = not assessed	
Check the impairment level for each category.	
Mood Disturbance (depression, mania)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Anxiety	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Psychosis	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Thinking/cognition/memory	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Impulsive/recklessness/aggressive	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Activities of daily living	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Weight change associated with Behavioral Health diagnosis ☐ Gain ☐ Loss lbs in last three months	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Medical/physical conditions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Substance abuse/dependence	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Job/school performance	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Social/marital/family problems	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Legal	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Stressors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Orientation/alertness /awareness	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Current/Previous Treatment

Is a psychiatrist involved in the member's care? ☐ **Yes** ☐ **No**

If **Yes**, when was the member last seen and what services are being rendered?

History of hospitalization in the past year? ☐ **Yes** ☐ **No**

If **Yes**:

Name of Provider / Facility	Dates	Compliant
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**

Is a therapist currently involved in the members care? ☐ **Yes** ☐ **No**

If **Yes**:

Name of Provider / Facility	Dates	Compliant
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**

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Current/Previous Treatment

Please list any other treatment received over the past two years:

Name of Provider / Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Current Medications (Psychotropic and Medical)

Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Are there any medication contraindications? If yes, please describe: ☐ **Yes** ☐ **No** If **yes**, please describe:

Additional Clinical Information

Is the member at risk of legal intervention or out-of-home placement? Describe:

Describe the overall risk of harm (to self or others):

What are the environmental/community stressors and/or supports that contribute to the member's clinical status?

Support System (Describe):

Describe the member/family engagement in treatment:

Current living situation? ☐ Homeless ☐ Independent ☐ Family ☐ Foster home ☐ Incarcerated ☐ Other:

Detail the discharge plan: