



Service Request Form for Psychiatric Inpatient Admission

Phone Number: 1-800-818-5837 Fax Number: 1-866-617-4967

Section 1 Member Information		
Member Name: (Last, First, MI)	Date of Birth: / /	Member I.D:
Address: (No., Street, City, State, Zip)		Phone Number: ()
No. of hospital days requested: Dates / / to / /		
Section 2 Facility Information		
Name (Contact):	Phone Number:	Fax Number:
Address:	()	()
TPI:	NPI:	Is Member court ordered: Yes No
Referral Source: Admitting MD MH Professional Other (list):		
Section 3 Primary Symptoms		
a. Psychosis:	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions
b. Mood:	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Hypomania
c. Anxiety:	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Chronic Worrying
d. Cognitive:	<input type="checkbox"/> Dementia	<input type="checkbox"/> Delirium
e. Somatic:	<input type="checkbox"/> G. I.	<input type="checkbox"/> Pain
f. Development Disorders:	<input type="checkbox"/> Autism	<input type="checkbox"/> Aspergers
g. Disruptive Behavior:	<input type="checkbox"/> Oppositional/Conduct	<input type="checkbox"/> Impulsivity
h. Substance:	<input type="checkbox"/> Abuse	<input type="checkbox"/> Dependence
i. Learning/School/Work Problems:	_____	
j. Other Symptoms (Specify)	_____	
k. Suicidal Ideation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Homicidal Ideation: <input type="checkbox"/> Yes <input type="checkbox"/> No
		Other Self Harm: <input type="checkbox"/> Yes <input type="checkbox"/> No
Section 4 Additional Clinical Information		
Other relevant clinical information (reasons for less restrictive setting):	Psychiatric Medications:	
Section 5 Past Psychiatric and Substance Abuse History		
1. Number of previous inpatient admissions:	4. Past and present drug/alcohol usage?	
2. Date of most recent inpatient stay: / / to / /		
3. Previous ambulatory/outpatient treatment (provider or facility) if none why:		
Section 6 DSM-IV Diagnostic Codes/Service Request		
Axis I (Include all):	Axis II:	
Axis III:	Axis IV:	Axis V GAF:
Section 7 Discharge		
Projected discharge date (required): / /		
Aftercare Plan:		
Provider (include any contact information available):		
Section 8 Behavioral Health Authorization		
Authorization #:	Approved Duration:	
Section 9 Attending Provider Information		
Signature (attending MD):	Date: / /	
Print Name:	Provider License Number:	
This is not a guarantee of benefits, only a review of the requested services for appropriateness and necessity. Reimbursement is based on the benefits available at the time of the service.		
Signature:	Title:	

*Please attach additional information, if necessary.

For DALLAS Service Area STAR+PLUS Behavioral Health Services, contact NorthSTAR at 888-800-6799 or northstarcustomer@valueoptions.com