



Service Request Form for Extended 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:
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Section 2 Facility Information

Name (Contact): Address:	Phone Number: () ()	Fax Number: () ()
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No. of additional hospital days requested: Dates / / to / /	If member was not discharged by projected date please describe conditions that warrant continued inpatient stay:
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Section 3 Updated Clinical Presentation

a. Psychosis:	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions	<input type="checkbox"/> Loose Associations	<input type="checkbox"/> Dissociation	<input type="checkbox"/> Inappropriate Affect
b. Mood:	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Hypomania	<input type="checkbox"/> Mania	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Concentration
	<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Loss of Motivation/Pleasure		<input type="checkbox"/> Worthlessness / Guilt	
c. Anxiety:	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Chronic Worrying	<input type="checkbox"/> Obsessive Thoughts	<input type="checkbox"/> Compulsive Behaviors	<input type="checkbox"/> Hyper Vigilance
d. Cognitive:	<input type="checkbox"/> Dementia	<input type="checkbox"/> Delirium	<input type="checkbox"/> Distractible		
e. Somatic:	<input type="checkbox"/> G. I.	<input type="checkbox"/> Pain	<input type="checkbox"/> Conversion/Pseudoneurologic		
f. Development Disorders:	<input type="checkbox"/> Autism	<input type="checkbox"/> Aspergers	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Other Learning Problems	
g. Disruptive Behavior:	<input type="checkbox"/> Oppositional/Conduct	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Attention
h. Substance:	<input type="checkbox"/> Abuse	<input type="checkbox"/> Dependence (Specify Type) _____			
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 Treatment Progress

(Relevant clinical/diagnostic information about the patient from the past 72 hours; include any DSM-IV changes):

Section 5 Current Psychiatric Medication Regimen

Any changes in psychiatric medications:
Previous dosage:
New Projected discharge date (required): / /
Provider Information:
Aftercare Plan:

Section 6 Attending Provider Information

Signature (attending MD):
Date: / /

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.

**Please attach additional information, if necessary.*