BEHAVIORAL HEALTH
RETROSPECTIVE CLINICAL REVIEW FORM

(Please address each area. An incomplete form may result in a delay of your request.)

Submit completed form to:

Email: BHRequests@Molinahealthcare.com

Fax: 505.924.8237 or 888.295.5494

Date Form Completed:

FACILITY INFORMATION

Name of Facility:

Out of State Facility (Y/N):

National Provider ID:

Address/Service Location:

Facility/Program Contact (Name):

Phone:

Fax:

Requested Level of Care (LOC):

Date of Admission:

Date of Discharge:

Requested Dates of Service:

Requested Number of Service Units:

MEMBER INFORMATION

**Please complete applicable fields.*

Member Name (First/Last):

Member ID or SSN:

Member DOB:

Member Age:

Name of Legal Guardian:

Guardian Address:

Guardian Phone:

Consumer's currently lives with (homeless, parents/siblings):

Is the member involved with CYFD-CPS (Yes/No)?

Is the member currently in custody of CYFD (Yes/No)?

If Yes, CYFD SW Name/Phone:

Is the member involved with Adult Protective Services?

If Yes, APS SW Name/Phone:

Is member involved with CYFD Juveniles Justice Services (JJS) (Y/N)?

If Yes, JJS Name/ Phone:

Power of Attorney (POA) Name/Phone:

Treatment Guardian Name/Phone:

DD Waiver Status:

RETROSPECTIVE REQUEST INFORMATION

Reason Prior-authorization was not requested:

CLINICAL INFORMATION

*****Please highlight the information requested below in the clinical chart or answer questions below.***

Summarize or highlight symptoms and behaviors that required the Level of Care Requested (Please provide specific dates and specify intensity, frequency and duration.):

DSM DIAGNOSES

**Include any updates during course of treatment; please note discharge information is requested separately at the end of document.*

DSM Diagnosis (Include DSM codes):

Description of Medical Needs (Including DME and chronic/co-morbid conditions):

MENTAL STATUS EXAM

**Include any updates during course of treatment; please note discharge information is requested separately at the end of document.*

Summarize or highlight Mental Status Exam during the course of treatment being requested:

MEDICATIONS

**Include any updates during course of treatment; please note discharge information is requested separately at the end of document.*

Summarize or highlight medications during the course of treatment being requested (Please include Name, Dose, Frequency Taken, Date Started and Prescriber.):

Was member adherent to medication (Yes/No)?

If No, why not?

Response to medication:

COURSE OF TREATMENT INFORMATION

Summarize or highlight Treatment Plan (Include Long Term Goals, Short Term Objectives and interventions with timeframes that focus on identified problem areas in current clinical presentation documented above.):

DISCHARGE INFORMATION

***If member discharged, please highlight discharge information in clinical chart or answer questions below. ***

Reason for discharge (describe if planned discharge/treatment completed, needs higher LOC, left AMA, elopement, Other):

Mental Status Upon Discharge:

Member discharged to (address/Phone Number):

If member is DC to an out of home placement/ LOC:

Agency name

Agency Contact:

PCP notified of discharge Yes/No?

If No, why not?

PCP name and contact information:

School notified of discharge Yes/No/NA?

If No, why not?

Probation notified of discharge Yes/No/NA?

If No, why not?

DSM DIAGNOSES UPON DISCHARGE

DSM Diagnosis (Include DSM codes):

Description of Medical Needs (Including DME and chronic/co-morbid conditions):

DISCHARGE MEDICATIONS

Please include Name, Dose, Frequency Taken, Date Started, Prescriber.

Is member adherent to medication (Yes/No)?

If No, why not?

Response to medication:

Who will monitor medications after discharge?

AFTERCARE PLAN

**Please make an effort to schedule Follow-Up Behavioral Health Appointments within 7 days of discharge per HEDIS measure requirements.

List Scheduled appointments: (include appointment dates and times, contact information for provider):

Barriers to successful implementation of aftercare plan?

Referred to Core Service Agency (CSA) Yes/No?

CSA name:

Additional comments/notes: