AmeriHealth Caritas VIP Care

Behavioral Health Clinical Fax Form

Please use the fax number listed below that corresponds to the state where the AmeriHealth Caritas VIP Care plan operates					
Delaware	Florida	Louisiana	Michigan	North Carolina	Pennsylvania
1-866-329-3324	**1-833-329-3524**	**1-866-565-2583**	**1-855-329-6400**	**1-833-362-7262**	**1-855-396-5750**

Today's date: _____ **Date of admission or service start:** _____

Type of review	**Estimated length of stay**
☐ Precertification ☐ Continued stay ☐ Discharge	(days/units)
Type of admission	
☐ Intensive outpatient ☐ Mental health inpatient ☐ Partial hospitalization program ☐ Substance use detox in a hospital setting	
Admission status	**Readmission within 30 days**
☐ Voluntary ☐ Involuntary commitment	☐ Yes ☐ No

Member information	
Last, first, middle initial:	Date of birth:
Address:	Eligibility ID:
Emergency contact (other than primary caregiver):	Phone:
Parent, guardian, or legal representative:	Phone:

Provider information		
Facility or provider name:	NPI or tax ID:	Provider ID:
Address:	Attending M.D.:	
UM Review contact:	Phone:	
DSM-5 diagnoses (include mental health, substance use, and medical):		

Medications				
Medication name	**Dosage**	**Frequency**	**Date of last**	**Type of change**
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
Additional information:				

Presenting problem or current clinical update (e.g., suicidal ideation, homicidal ideation, psychotic symptoms, mood/affect, sleep, appetite, withdrawal symptoms, chronic substance use)

Treatment history and current treatment participation
Previous mental health or substance use inpatient, rehab, detox:
Outpatient treatment history:
Is the member attending therapy and groups? ☐ Yes ☐ No Explain clinical treatment plan:
Family involvement and support system:
Substance use: ☐ Yes ☐ No If yes, for mental health services only, please explain how substance use is being treated.

Please complete below for current American Society of Addiction Medicine (ASAM) dimensions and/or submit with documentation for substance use detox.

Dimension rating (0 – 4) Current ASAM dimensions are required.	
Dimension 1: Acute intoxication and/or withdrawal potential	**Rating:**
Substances used (pattern, route, last used):	
Tox screen completed? ☐ Yes ☐ No If yes, results:	
History of withdrawal symptoms:	
Current withdrawal symptoms:	
Dimension 2: Biomedical conditions and complications	**Rating:**
Vital signs:	
Is member under a health care provider's care? ☐ Yes ☐ No Current medical conditions:	
History of seizures? ☐ Yes ☐ No	

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Dimension rating (0 – 4) continued Current ASAM dimensions are required.	
Dimension 3: Emotional, behavioral, or cognitive conditions and complications	**Rating:**
Mental health diagnosis:	
Cognitive limits? ☐ Yes ☐ No	
Psych medications and dosages:	
Current risk factors (e.g., suicidal ideation, homicidal ideation, psychotic symptoms):	
Dimension 4: Readiness to change	**Rating:**
Awareness and commitment to change:	
Internal or external motivation:	
Stage of change, if known:	
Legal problems/probation officer:	
Dimension 5: Relapse, continued use, or continued problem potential	**Rating:**
Relapse prevention skills:	
Current assessed relapse risk level: ☐ High ☐ Moderate ☐ Low	
Longest period of sobriety:	
Dimension 6: Recovery and living environment	**Rating:**
Living situation:	
Sober support system:	
Attendance at support group:	
Issues that impede recovery:	

Discharge planning
Discharge planner name and contact:
Residence address upon discharge:
Treatment setting and provider upon discharge:
Has a post-discharge seven-day follow-up aftercare appointment been scheduled? ☐ Yes ☐ No If no, please explain: If yes, please provide treatment provider name and date and time of scheduled follow-up:

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