

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
<input type="checkbox"/> Precertification <input type="checkbox"/> Continued stay <input type="checkbox"/> Discharge	(days/units)
Type of admission	
<input type="checkbox"/> Intensive outpatient <input type="checkbox"/> Mental health inpatient <input type="checkbox"/> Partial hospitalization program <input type="checkbox"/> Substance use detox in a hospital setting	
Admission status	Readmission within 30 days
<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary commitment	<input type="checkbox"/> Yes <input type="checkbox"/> 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
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Current medical conditions:	
History of seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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:

Original December 19, 2025