**Thurston Mason BH-ASO Non-Medicaid ITA Concurrent Review Form**

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| **PATIENT DEMOGRAPHICS** |

Patient Full Name:       Date of Birth:       P1 ID, if applicable:       SSN:       Gender:

Street Address:       City:       Zip Code:

United States Citizen? Yes No – If no, Start the AEM Application process immediately.

County of Residence:       Current Living Situation:

**Involuntary Psych IP ordered by*:***  Court  DCR  Other:       **County of Detainment**:       - **Please** **include detainment documents.**

Length of Current ordered hold:       Start Date:       Next Court Date:

**Continued Stay request?** , or **Retro Extension request?**  **Date** **&** **Time** of request:       **Auth# from TMBH-ASO**:

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| **PROVIDER INFORMATION** |

**Date & Time** of Patient ITA Admit       Provider Agency Name:       Provider Agency NPI:       Provider Location:

Facility UR Name:       Phone:       Fax:       Email:

Attending Treatment Psychiatrist/Physician Name:

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| **CLIENT STATUS** |

**CURRENT PRESENTATION:**

Current primary presenting issue:

Current evidence of symptoms, (e.g., psychosis, depression, anxiety, etc.)? Yes No **If yes**, please describe.

Cognitive impairment? Yes No **If yes**, please describe, (e.g., Dementia, TBI, Developmental Disability).

Can a Behavioral Health diagnosis be determined?Yes No

ICD-10 Code & DSM-5 Primary Diagnosis       ICD-10 Code & DSM-5 Secondary Diagnosis

Tox Screen Completed? Yes No Tox Screen result:       BAL result:

Comorbid? (Medical or Substance Use): Yes No **If yes**, please describe.

Suicidal Ideation? Yes No **If yes**, please describe if client has realistic means and/or access.

Presence of other risk factors? Yes No **If yes**, please describe.

Presence of protective factors for Suicidal Ideation, (e.g., social supports, spirituality, family, children in home)?

Any concerns related to thoughts of harm to others due to mental status? Yes No **If yes**, please describe.

How do current symptoms create imminent risk or extreme functional impairment?

HCS involvement? Yes No **If yes**, please describe how they are involved.

DDA involvement? Yes No **If yes**, please describe how they are involved.

**TREATMENT PLAN, ANTICIPATED OUTCOMES, AND DISCHARGE PLAN:**

Treatment Plan Summary, (e.g., Medical interventions, tests planned, psych interventions planned, goal of hospital).

Please describe any barriers for discharge, (e.g., housing, cognitive impairment).

Expected outcomes from IP stay:

Psychiatric Medications:

Expected discharge date determined by treating Physician:

Have OP providers who accept client’s benefit been contacted for follow up care arrangement? Yes No **If yes**, Provider’s Name.

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| **BENEFIT INFORMATION** |

**MEDICAID APPLICATION STATUS:**

Pending **– If so, what date was application submitted?**

Not yet applied – **If so, please explain why.**

Not eligible – **If not eligible, please explain why.**        **please submit supporting documents showing ineligibility, unless already provided.**

**Is the patient on a Spenddown?** Yes No – If yes, what is the total amount?

**Other Benefit Plan**:  Medicare – Bed Days Remaining:        Commercial/Other – Benefit Name?        None

Benefit contacted for Authorization? Yes No Comments:

Request Results:       Benefit Contact Name:       Phone:       Fax:       Email:

**Please submit determination documentation from other benefit with this form. (Required to receive payment from TMBH-ASO)**

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| **REQUEST FORM INSTRUCTIONS** |

Send **fully completed** form and **all supporting** documents via **Encrypted** email to: [iprequest@tmbho.org](mailto:iprequest@tmbho.org).

* **Thurston Mason BH-ASO reserves the right to deny authorization requests that do not meet our state-directed policy for timely Non-Medicaid ITA authorizations.**
* Notification to Thurston Mason BH-ASO is **required** for all Involuntary Non-Medicaid admissions requests within **24 hours of admission.**
* Concurrent review forms are due **24 hours prior to the end date** of current authorized length of stay.
* This form should be filled out electronically. Handwritten forms may be sent back without authorization.
* **Discharge summaries** are **required** to be faxed into TMBH-ASO at: 360-489-1435, or emailed securely to [iprequest@tmbho.org](mailto:iprequest@tmbho.org).
* Discharge summaries are required to receive any payment from TMBH-ASO.

TMBH-ASO will reply to request emails with an Authorization number, authorized extension length, or report a determination to the listed UR Email above the following business day.

Questions? Contact us at: Main Line: 360-763-5828 or UM Specialist: 360-763-5805