**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.

* **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.
* 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