Companion
BENEFIT ALTERNATIVES

Phone: 800-868-1032
Fax: 803-714-6456
www.CompanionBenefitAlternatives.com

Facility-Based Treatment Form
Required Elements for Medical Necessity Review

We offer several options for requesting authorization of services. For fastest results, use our new Form Resource Center. These secure, Web-based forms are available 24 hours per day at **https://forms.companionbenefitalternatives.com.**

You can also fax your authorization request. Forms are available for download on our website, www.CompanionBenefitAlternatives.com, or you can call to request them.

Whichever method you choose, please complete the form in its entirety. We cannot process your authorization request without all required elements. To avoid delays, please include this information, when applicable:

- Reason for admission.
- Presentation of current symptoms and behaviors to include mental status. Detailed symptoms for psychosis, mania and decline in function.
- Reason for involuntary status. Projected court date and outcome.
- If member is suicidal or homicidal, please include plan (means) and intent, if any.
- Include the current treatment plan on admission. For updates, include any changes to the treatment plan and progress.
- If request is for substance abuse (SA) treatment, please include substances used and these:
    - Frequency.
    - Duration.
    - Date of last use.
    - For detoxification, please include history of all that apply:
        - List of withdrawal symptoms.
        - Vital signs.
        - Urine drug screening (UDS) results.
        - Seizures.
        - Delirium tremens (DT).
        - Clinical institute withdrawal assessment for alcohol scale (CIWA).
        - Clinical opiate withdrawal scale (COWS).
- If SA treatment request is for partial hospitalization (PHP) or intensive outpatient program (IOP), include:
    - 12-step attendance.
    - Sponsor status.
    - Cravings status/management.
- If electroconvulsive therapy (ECT), please list symptoms, behaviors and mental status. Please include:
    - Prior ECT.
    - Prior medication trials.
    - Number of treatments requested.
    - Frequency of treatment.
    - Total number of treatments given.
    - Electrode placement.
- List any prior mental health (MH) or SA inpatient, partial hospitalization, intensive outpatient, residential, ECT or office visits. Include type of treatment with name of facility and dates of service.
- Result of family session(s), date of scheduled session or reason if none occurred.
- List follow-up details to include:
    - PHP, IOP, outpatient, office-based therapy, treatment by primary care physician, family support, medication, etc. Include times and dates.
    - Housing/living situation.
    - Ability to return to work/school.

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Facility-Based Treatment Form

** - required information*

Facility's Name*: _____ Facility's Phone*: _____
Facility's Fax*: _____ Facility's NPI*: _____
Physical Address 1*: _____ Physical Address 2: _____
City*: _____ State*: _____ ZIP Code*: _____

Attending MD's First Name*: _____ Attending MD's Last Name*: _____

Utilization Review (UR) Name*: _____
UR Contact Number*: _____ UR Fax Number*: _____

Patient's First Name*: _____ Patient's Last Name*: _____
Date of Birth*: _____ ID Card Number*: _____
Phone: _____ Email: _____

Please indicate if this Facility-Based Treatment is* ☐ **an Initial Review or** ☐ **a Continued Review.**

Level of Care*:

☐ IP-Psych	☐ IP-Detox	☐ IP-Rehab	☐ IP-Eating Disorder	☐ IP-ECT
☐ PHP-Psych	☐ PHP-CD	☐ PHP-Eating Disorder	☐ IOP-Psych	☐ IOP-CD
☐ RTC-Psych	☐ RTC-Rehab	☐ RTC-Eating Disorder	☐ IOP-Eating Disorder	☐ OP-ECT

If level of care is PHP or IOP, please indicate:
Duration of sessions: _____ ☐ a.m. ☐ p.m. to _____ ☐ a.m. ☐ p.m. on ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

Date of Admission*: _____ **Estimated Date of Discharge*:** _____

Diagnosis: ☐ **Change** ☐ **No change**

Axis I* _____
Axis II _____
Axis III _____
Axis IV _____
Axis V Initial GAF*: _____
Current GAF*: _____

Legal Commitment Papers*: ☐ **Yes** ☐ **No**

If yes, explain:
_____
_____
_____
_____
_____

Current Symptoms*: _____
_____
_____
_____
_____
_____

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Treatment Plan*: _____

_____

_____

_____

_____

Treatment History*: _____

_____

_____

_____

_____

_____

Does the patient have prior medications?* ☐ **Yes** ☐ **No**
If yes, please complete:

Medication's Name	Dose	Frequency

Does the patient have current medications?* ☐ **Yes** ☐ **No**
If yes, please complete:

Medication's Name	Dose	Frequency	Anticipated Changes

Specify Support System*: _____

_____

_____

_____

Discharge Plan*: _____

_____

_____

_____

If this is for a Continued Review, please answer:

Please make follow-up appointments within seven days after discharge. Will you need assistance in getting an appointment for the member within this timeframe? ☐ Yes ☐ No

Will you be sending a copy of the patient's discharge summary to the patient's primary care physician? ☐ Yes ☐ No

Certification is not valid until Companion Benefit Alternatives issues a certification number.