



Behavioral Health Utilization Management Inpatient Request Form

Kansas | Healthy Blue | Medicaid

Fax number: 866-852-8976

MEMBER DEMOGRAPHICS					
First name:			MI:		
Last name:			Date of birth:		
Medicaid ID:					
Other insurance:					
Address city/county:				ZIP:	
Telephone:	Current living arran	Current living arrangement:		Foster care involvement:	
Guardian name:		Guardian phone:			
HOSPITAL INFORMATION					
Requesting hospital:					
Requesting NPI:		Requesting TIN:			
Requesting hospital fax:		Requesting hospital phone:			
Hospital UM/Reviewer:	Phone:	Hospital discharge	planner:	Phone:	
Attending physician:		Attending physician phone:			

REQUEST INFORMATION				
□ Initial request	□ Continued stay request	Admission assessment:		
Level of Urgency		Admission date		
	-	Admission time:	□ a.m.	
	□ Retro		□ p.m.	

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.

Healthy Blue is the trade name of Community Care Health Plan of Kansas, Inc., an independent licensee of the Blue Cross and Blue Shield Association. KSHB-CD-074464-24 January 2025

The requesting physician must sign urgent requests to receive priority. Physician signature requests for urgent requests only:			
X			
Primary procedure code/modit	fier:	Expected length of stay:	

MEMBER CLINICAL INFORMATION				
Current diagnosis:	Additional diagnoses:			
Circumstances of admission:				
□ Outpatient referral □ Emergency room □ Marriage fami	ily therapist (MFT) Transfer from intensive care unit (ICU)			
Medical Self-referral Other				
Current symptoms and behaviors that require admission:				
Results of Lethality Assessment: Describe the current plan a	nd level of intent:			
Current behavioral health services:	Discharge placement:			
Current benavioral nealth services.	Discharge placement:			
Previous SI/HI/Self-harm:	Current mental status exam:			
History of prior psychiatric hospitalizations:	Abuse and trauma history:			
nistory of prior psychiatric hospitalizations.	Abuse and trauma history:			
Parent incarceration \Box Yes \Box No	Court Order Yes 🗆 No 🗆			
Parent separation/divorce	Domestic ViolenceYesNo			
Death of a family member \Box Yes \Box No	Peer abuse/bullying Yes No			
	Substance Use contributing factor Yes No			
Vital signs:	Labs:			
Blood pressure: Temperature:				
Respirations: Pulse: Other				
Current psychotropic medications:				

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Compliant with current medications: Yes No				
Medical issues:				
2				
Discharge barriers/cultural considerations:				
Services and providers the member will utilize upon discharg	je:			
Other clinical information: (also please feel free to attach any	additional clinical information)			
Discharge date:				
Did the member attend a 510/513 (Bridge) appointment duri	ng the discharge process? \Box Yes \Box No			
If yes, the name of the staff conducting the 510/513:				
Date of the 510/513:				
Outpatient therapist:	Phone:			
Data of pout appointment	Time of encountments			
Date of next appointment:	Time of appointment:			
Case manager (if applicable):	Phone:			
Psychiatrist:	Phone:			
Date of next appointment:	Time of appointment:			
Does member have medication to last until psychiatrist's follow up? Ves No				
Other follow up appointment:	Phone:			
Name/type of provider:				
Date of next appointment:	Time of next appointment:			
Medical provider/PCP:	Phone:			
Discharge diagnosis:	Medications at discharge:			
Discharge disposition/where will member be staying after discharge:				