Select Health of South Carolina, Inc.
An AmeriHealth Mercy Company

Behavioral Health Fax Form

When complete, please fax to 888.796.5521.

Type of Review: ☐ **Precertification** ☐ **Continued stay** ☐ **Discharge**

Type of Admission: ☐ **Observation** ☐ **Mental health** ☐ **Substance abuse detox** ☐ **Substance abuse rehab**

Member Information

Member name ____________________ Medicaid # ____________________

Member DOB ______________ Today's date ______________ Admission date ______________

Admission committment status: ☐ Voluntary ☐ Involuntary

Provider Information

Provider name *(as credentialed with Select Health)* ____________________

Provider address ____________________

Contact person ______________ Contact fax ______________ Contact phone ______________

DSM-IV Multiaxial Diagnosis *Please complete all 5 axes*			
Axis I	☐☐☐.☐☐/☐☐☐.☐☐		
Axis II	☐☐☐.☐☐/☐☐☐.☐☐		
Axis III			
Axis IV	☐ Mild	☐ Moderate	☐ Severe
Axis V: GAF	Admission:	Highest:	Current:

Medications

Medication name	**Dosage**	**Frequency**	**Date of last change**	**Type of change**
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
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				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New
				☐ Increase ☐ Decrease ☐ Discontinue ☐ New

HEALTH PLAN NCQA ACCREDITATION EXCELLENT MEDICAID

Behavioral Health Fax Form continued

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Presenting problem or current clinical update (*Suicidal, homicidal, psychotic, mood/affect, sleep, appetite, etc.*).

Is he/she attending groups? ☐ Yes ☐ No ☐ N/A (this is a precertification) **If so, please indicate group participation below.**

Describe family involvement and support systems.

Does he/she have substance abuse issues? ☐ Yes ☐ No **If so, please indicate how they are being addressed.**

Discharge planning.

Aftercare appointment(s): Aftercare phone:

Aftercare address: Provider name:

Member address: Member phone:

Page 2 of 2 for member name:

Medicaid ID#: