KanCare Behavioral Health Inpatient Request Form (page 1-3)

AETNA BETTER HEALTH	SUNFLOWER HEALTH PLAN	UNITED HEALTHCARE
Fax 1-855-225-4102 Phone 1-855-221-5656	Fax 1-844-824-7705 Phone 1-877-644-4623	Fax 1-855-268-9392 Phone 1-855-802-7095

MEMBER DEMOGRAPHICS			
First name			MI
Last name			Birthdate
Medicaid ID			
Other insurance			
Address City/county			zip
Telephone	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 D/C Planner	Phone
Attending Physician		Attending Physician phone	

REQUEST INFORMATION			
Initial request ☐	Continued stay request ☐	discharge notification ☐ (skip to page 3 for discharge summary)	Admission Assessment Voluntary ☐ Involuntary ☐
Level of Urgency	Standard ☐ Urgent ☐ Retro ☐	Admission date	
		Admission time ☐ AM ☐ PM	
Urgent requests must be signed by the requesting physician to receive priority. Physician signature requests for urgent requests only: X_____			
Initial request ☐	Continued stay request ☐	discharge notification ☐ (please only complete section on page 3 for discharge)	Admission Assessment Voluntary ☐ Involuntary ☐
Primary procedure code/Modifier			Expected length of stay

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MEMBER CLINICAL INFORMATION	
Current diagnosis	Additional diagnoses
Circumstances of Admission: (OP referral, ER, MFT, Transfer from ICU, medical, self-referral, other)	
Current Symptoms and behaviors which require admission:	
Results of Lethality Assessment: Describe current plan and level of intent	
Current behavioral health services	Discharge placement
Previous SI/HI/Self-harm	Current Mental Status Exam
History of prior psychiatric hospitalizations	Abuse and Trauma history
Parent Incarceration Yes ☐ No ☐ Parent separation/divorce Yes ☐ No ☐ Death of a family Member Yes ☐ No ☐	Court Order Yes ☐ No ☐ Domestic Violence Yes ☐ No ☐ Peer abuse/bullying Yes ☐ No ☐ Substance Use contributing factor Yes ☐ No ☐
Vital signs: Blood pressure Temperature Respirations Pulse Other	Labs
Current psychotropic medications: Compliant with current medications: Yes or NO	
Medical issues:	
Discharge Barriers/cultural considerations:	
Services and providers member will utilize upon discharge:	

Other clinical information: (also please feel free to attach any additional clinical information)

DISCHARGE SUMMARY (page 3 of 3)

Discharge Date:	
Did member attend a 510/513 (Bridge)appt. during the discharge process Yes or No	
If yes, name of staff conducting the 510/513:	
Date of the 510/513:	
Outpatient therapist:	Phone:
Date of next apt:	Time of apt:
Case manager (if applicable):	Phone:
Psychiatrist:	Phone:
Date of next appointment:	Time of apt:
Does member have medication to last until psychiatrist follow up no yes	
Other follow up appt Name/type of provider:	Phone:
Date of next appt:	Time of next apt:
Medical provider/PCP:	Phone:
Discharge Diagnosis:	Medications at discharge:
Discharge disposition/where will member be staying after discharge:	