5300 Homestead Rd NE
Albuquerque, NM 87110

Behavioral Health
Retrospective Clinical Review Form

(Address all areas. An incomplete form may result in a delay of your request.)

Submit completed form to:

Online: Provider Portal

Fax: 844-618-9572

Date Form Completed:

Facility Information

Name of Facility:

Out of State Facility: YES NO **National Provider ID:**

Address/Service Location:

Facility/Program Contact:
(Name)

Phone: **Fax:** **Date of Admission:**

Level of Care Requested:
(include Billing Code)

Requested Dates of Service: **Requested Number of Service Units:**

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Member Information

Member Name:
(First/Last)

Member ID or SSN: Member DOB: Member Age:

Name of Legal Guardian:

Guardian Address: Phone:

Consumer's currently lives with:
(homeless, parents/siblings)

Is the member involved with CYFD-CPS? YES NO

Is the member currently in custody of CYFD? YES NO

If Yes, CYFD SW Name: Phone:

Is the member involved with Adult Protective Services? YES NO

If Yes, APS SW Name: Phone:

Is member involved with CYFD Juveniles Justice Services (JJS)? YES NO

If Yes, JJS Name: Phone:

Power of Attorney (POA) Name: Phone:

Treatment Guardian Name: Phone:

DD Waiver Status:

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Retrospective Request Information

Reason Prior-authorization was not requested:

Clinical Information

Please highlight the information requested below in the clinical chart or answer questions below.

Summarize or highlight symptoms and behaviors that required the Level of Care Requested:
(Please provide specific dates and specify intensity, frequency and duration.)

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DSM Diagnoses

Include any updates during course of treatment; please note discharge information is requested separately at the end of document.

DSM Diagnosis:
(Include DSM codes)

Description of Medical Needs:
(Including DME and chronic/co-morbid conditions)

Mental Status Exam

Include any updates during course of treatment; please note discharge information is requested separately at the end of document.

Summarize or highlight Mental Status Exam during the course of treatment being requested:

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Mental Status Exam

MSE was completed by:
(Name)

Date Completed:

If not completed, why not?

Appearance and Behavior:
(posture, gestures, attire, facial expressions and speech)

Attention:
(normal, alter, impaired)

Mood:
(normal, euphoric, agitated, sad, etc.)

Affect:
(appropriate, inappropriate, flat, etc.)

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Perception:
(hallucinations, delusions, etc.)

Thought Content/Process:
(logical, de-realizations, SI/HI, etc.)

Orientations:
(time, person, place, circumstances)

Insight:
(good/fair/poor/absent)

Activities of Daily Living:
(i.e. within normal limits, impaired)

Sleep:
(e.g. disturbed, early morning awakening, etc.)

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Medications

Include any updates during course of treatment; please note discharge information is requested separately at the end of document.

Summarize or highlight medications during the course of treatment being requested:
(Please include Name, Dose, Frequency Taken, Date Started and Prescriber.)

Was member adherent to medication? YES NO

If No, why not?

Response to medication:

Course of Treatment Information

Summarize or highlight Treatment Plan:
(Include Long Term Goals, Short Term Objectives and interventions with timeframes that focus on identified problem areas in current clinical presentation documented above.)

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Discharge Information

If member discharged, please highlight discharge information in clinical chart or answer questions below.

Reason for discharge:
(describe if planned discharge/treatment completed, needs higher LOC, left AMA, elopement, other)

Mental Status Upon Discharge:

Member discharged to:
(Address/Phone Number)

If member is DC to an out of home placement/LOC

Agency Name: **Agency Contact:**

PCP notified of discharge? YES NO N/A

If No, why not?

PCP Name: **Contact Information:**

School notified of discharge? YES NO N/A

If No, why not?

Probation notified of discharge? YES NO N/A

If No, why not?

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DSM Diagnoses Upon Discharge

DSM Diagnosis:
(Include DSM codes)

Description of Medical Needs:
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Discharge Medications

Please include Name, Dose, Frequency Taken, Date Started, Prescriber.

Was member adherent to medication? YES NO

If No, why not?

Response to medication:

Who will monitor medications after discharge?

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Aftercare Plan

Please make an effort to schedule Follow-Up Behavioral Health Appointments within 7 days of discharge per HEDIS measure requirements.

List Scheduled appointments:
(include appointment dates and times, contact information for provider)

Barriers to successful implementation of aftercare plan?

Referred to Core Service Agency (CSA)? YES NO

CSA name:

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Additional Comments/Notes:

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