ValueOptions - TRICARE Higher Level of Care Treatment Report
Guidelines for Using the Form

EACH TIME YOU FAX A REVIEW IN, PLEASE USE A NEW FORM AS THE PATIENT'S CONDITION CONSTANTLY CHANGES. PLEASE TYPE OR LEGIBLY PRINT (USING DARK INK) ALL INFORMATION.

IF YOU KNOW THE NAME OF YOUR TRICARE - ValueOptions REVIEWER, PLEASE PUT THEIR NAME ON YOUR FAX COVER SHEET OR ON THE HIGHER LEVEL OF CARE DOCUMENT.

Level of Care: Each time you fax this document, please place an "X" in the Level of Care box. Only one box can be checked.

Type of Review: **Each** time you fax the document please put an "X" in the appropriate box.

- **Initial-**This is your first fax/review. This is your initial request for authorization for treatment.
- **Concurrent**-These are fax reviews after the initial review. We have already authorized the admission and you are faxing us updates. Please fax in a new document for each update.
- **Discharge**-This is a fax you send us telling us the patient is discharged and specific information related to the discharge. Please fax in a new document for the discharge.

Patient Name: First Name, Middle initial (if applicable), and Last name

Date of Birth: Month/Date/Year of the patient's birth.

Sponsor's SSN: **SSN OF THE SPONSOR, NOT THE PATIENT, UNLESS THE PATIENT IS THE SPONSOR**. A sponsor is the policy holder-- active duty military, retired military or disabled former military.

Date Form Completed: The actual date you complete the form, which is usually the date you fax it to us. **Remember, please fax in a new document for each update.**

Facility: The full name of your hospital or facility

Facility Tax ID: The facility/hospital Tax I.D. (including any applicable suffixes).

Attending Provider: First and Last Name of the Doctor who will be attending to the patient's care.

Attending's Phone: Phone number of the attending's office, (our physician may need to call the attending, we will notify you first).

UR Contact: Name of the person at the hospital/facility that will be working with us for continued fax reviews.

UR Contact Phone Number: Phone number and ext. if applicable, of the person at the hospital/facility that will be working with us for continued fax reviews.

Fax: Fax number and of the person at the hospital/facility that will be working with us for continued fax reviews.

Current Assessment of Risk: Circle what is applicable. Usually reflects the last 24-48 hours of notes prior to faxing an update to us.

Substance Abuse/ Dependence: Severity of substance use with the date of last use for each substance.

ICD-9 Diagnosis Codes and Axis – ** **The diagnosis must relate to the level of care that is being requested when the Initial/Admission fax is sent to us.** ** **At discharge, if the diagnosis has changed from admission and subsequent reviews, please put in the discharge diagnosis and write in the box, D/C DX ****

Admit Date: The formal date the patient was admitted to your hospital/facility.

Time: The time the patient was admitted to the unit or program.

Planned Discharge Residence: Should be on the form on the first concurrent review and subsequent reviews. Discharge planning begins at admission.

Anticipated date of discharge – IMPORTANT- At each fax review please fill this out. If the attending does not have this documented in the chart, please ask him/her.

Current Medication / Dosing / Schedule: Only psychotropic medications need to be listed. The list should be current, from the chart, prior to faxing this document.

Current Rationale for Admission / Continued Stay: **THIS IS VERY IMPORTANT**.

- ****For the initial review fax-** what is the rationale for the admission- Medical/clinical documentation from the professional who evaluated the patient and determined that the admission was clinically and medically appropriate. ** Clarification/explanation of dangerousness or psychosis is very helpful here. This is the most basic issue why the patient cannot be treated outside of the hospital. Please note that you may also fax the admission evaluation note as an attachment to the HLOC document. **

- **For concurrent reviews- what is the rationale for the patient to remain in the current level of care. Clarification/explanation of dangerousness or psychosis is very helpful here. This is the most basic issue why the patient cannot be discharged or treated outside of the hospital. Medical/clinical information from the medical record- Most likely the last note from the attending physician and nursing notes. ** Please note that you may also fax the physician's rounding note and nursing notes as an attachment to the HLOC document. **

Discharge Information

- **D/C Date**- When the patient is discharged, please put the date here. Please put the medications at discharge in the Current Medications box.
- **Total # Days/Session Used**- When the patient is discharged, please put the total days for the inpatient stay or the total days attended for php.
- **Discharge Condition**- At discharge, please check the appropriate box.
- **Follow-up Provider/Facility**- Full names and credentials of professionals who the patient will follow up with or if transferred to a facility, the full name of the facility.
- **Follow-up Provider / Facility Phone number**- The telephone number of the each provider or facility the patient will be following up with.
- **Date / Time of first follow-up appointment**- The date and time of the first follow up appointment for each provider.

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Fax To: 1-866-811-4422

VALUEOPTIONS

TRICARE South

Level of Care: ☐ Inpatient ☐ RTC ☐ Psych PHP ☐ 1/2 Day Psych PHP ☐ IP Detox ☐ IP Rehab ☐ CD PHP ☐ 1/2 Day CD PHP

Type of Review: ☐ Initial ☐ Concurrent ☐ Discharge

Patient Name: ______

Date of Birth: ______

Sponsor's SSN: ______ **Date Form Completed:** ______

Facility: ______

Facility Tax ID: ______

Attending Provider: ______

Attending's Phone: ______

UR Contact: ______

UR Contact Phone Number: ______ **Fax:** ______

ICD-9 Diagnosis Codes

Axis I: ___.___ ___.___ ___.___

Axis II: ___.___ ___.___

Axis III: 1) ______

2) ______

Treatment
Admit Date: ______ **Time:** ______ ☐ Voluntary ☐ Involuntary

Planned Discharge Residence: ______

Anticipated date of discharge: ______

Current Assessment of Risk

Circle each. Scale: 0 = None 1 = Mild 2 = Moderate 3 = Severe 4 = Extreme

Item	Scale
ADLs	0 1 2 3 4
Aggression	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4
Delusions	0 1 2 3 4
Disorganization	0 1 2 3 4
Hallucinations	0 1 2 3 4
Impulsivity	0 1 2 3 4
Job/School Problems	0 1 2 3 4
Judgment/Insight	0 1 2 3 4
Medical Illness	0 1 2 3 4
Memory/Concentration	0 1 2 3 4
Mood Depression	0 1 2 3 4
Mood Elevation	0 1 2 3 4
Psychosis	0 1 2 3 4
Relationship Problems	0 1 2 3 4
Sleep Disturbance	0 1 2 3 4
Weight Loss / Appetite	0 1 2 3 4
Suicide	0 1 2 3 4
- Degree of Plan	0 1 2 3 4
- Access to Method	0 1 2 3 4
- Degree of Intent	0 1 2 3 4
- Lethality of Method	0 1 2 3 4

Item	Scale
Current Homicide / Violence	0 1 2 3 4
- Degree of Plan	0 1 2 3 4
- Access to Method	0 1 2 3 4
- Degree of Intent	0 1 2 3 4
- Lethality of Method	0 1 2 3 4

Substance Abuse/ Dependence:

Circle each. Scale: 0 = None 1 = Mild 2 = Moderate 3 = Severe 4 = Extreme

☐ None ☐ Continuous
☐ Episodic ☐ Tolerance

Substance:	Amount:
☐ Alcohol	0 1 2 3 4
☐ Opiates	0 1 2 3 4
☐ Benzodiazepines / Sedatives	0 1 2 3 4
☐ Marijuana	0 1 2 3 4
☐ Cocaine	0 1 2 3 4
☐ Hallucinogens	0 1 2 3 4
☐ Inhalants	0 1 2 3 4
☐ Other	0 1 2 3 4
☐ Withdrawal Symptoms	0 1 2 3 4
☐ Motivation / Insight	0 1 2 3 4
☐ Relapse Potential	0 1 2 3 4
☐ Support Systems	0 1 2 3 4

Date of Last Use: ______

Current Medication / Dosing / Schedule

1. ______
2. ______
3. ______
4. ______

Current Rationale for Admission / Continued Stay

______
______
______

Discharge Information

☐ Family involved ☐ Child Protective Service ☐ AMA
☐ Residential ☐ Partial Hospital ☐ Outpatient ☐ Other

D/C Date: ______ Total # Days/Session Used: ______

Discharge Condition: ☐ Improved ☐ No Change ☐ Worse

Follow-up Provider/Facility: ______

Follow-up Provider / Facility Phone number: ______

Date / Time of first follow-up appointment: ______

Please contact ValueOptions - TRICARE for assistance at 800-700-8646 with discharge planning or other needs. Submission of form does not automatically constitute authorizations.
All treatment is subject to medical necessity determination and is based on beneficiary eligibility.

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