



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

EACH TIME YOU FAX A CONCURRENT REVIEW IN OR DISCHARGE INFORMATION, 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 THIS RTC-HIGHER LEVEL OF CARE DOCUMENT.

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

- **Concurrent**-We have already authorized the admission and you are faxing us updates. Please fax in a new document for each update.
- **Discharge**-This is for providing 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.** 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 RTC hospital or facility

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

Attending Provider: First and Last Name of the Attending Doctor.

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

UR Contact: Name of the person at the RTC who will be, or is working, with us for continued fax reviews and discharge information.



UR Contact Phone Number: Phone number and ext. if applicable, of the person at the RTC who will be or who is working with us for continued fax reviews and discharge information.

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

ICD-9 Diagnosis Codes and Axis I – ** The diagnosis which is the primary focus of treatment. ** 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 the RTC.

Planned Discharge Residence: Where will the patient be living when they complete RTC. Discharge planning begins at admission.

Anticipated date of discharge and discharge plans (e.g.-Continuing treatment, etc.) – 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.

Rationale for Continued Stay: THIS IS VERY IMPORTANT.

- ****For concurrent reviews-** what is the rationale for the patient to remain in the RTC level of care. Clarify/explain why the patient needs to remain in RTC. The most basic issue here is why the patient cannot be discharged or treated outside of the RTC. Please read the medical record and provide us with the rationale.
- ****Family Therapy-** Please read the family therapy notes since your last faxed concurrent review and provide us with a synopsis of the most recent sessions. ***** Please do not put-“see notes” ***** Please attach the family therapy notes to the concurrent review document. *******
- ****Therapeutic Passes** (from admission to current) - If applicable, the date or dates and hours of passes.
- **Most recent M.D. Notes -** Please read the physician’s notes since your last faxed concurrent review and provide us with a synopsis of the Dr.'s rounds. ***** Please not put-“see notes” ***** Please attach the physician’s notes to the concurrent review document. *******

Discharge Information

- **D/C Date-** The date when the patient is discharged. 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 RTC stay.
- **Discharge Condition-** 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 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.

RTC (Residential Treatment Center)

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: _____

Rationale for Continued Stay:

Family Therapy (synopsis since last review): *Please attach all family therapy notes. Weekly family therapy is required by TRICARE policy.*

Therapeutic Passes (from admission to current):

Date	Hours of the pass
_____	_____
_____	_____

Type of Review: Concurrent Discharge

ICD-9 Diagnosis Codes

Axis I: _____ . _____ . _____ . _____ .
 Axis II: _____ . _____ .
 Axis III: 1) _____

Treatment

Admit Date: _____

Planned Discharge Residence: _____

Anticipated date of discharge/plans: _____

Current Medication / Dosing / Schedule

- _____
- _____
- _____
- _____

Most Recent M.D. Note (synopsis): *Please attach most recent MD note*

Discharge Information

Family involved Child Protective Service AMA
 Residential Partial Hospital Outpatient Other

D/C Date: _____ Total days used: _____

Discharge Condition: Improved No Change Worse

Follow-up Provider/ r(s) _____

Follow-up Provider r(s) _____ ; _____

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.