

Out of Home Concurrent Review Form

This form is to be typed.

Send completed form by fax to the BUHP Behavioral Health Prior Authorization Department at (520) 874-3411.

Member Name: _____ Date of Birth: _____

Outpatient Agency: _____ Outpatient CM: _____

OOH Provider Agency: _____

OOH Type: BHIF/RTC BHRF HCTC

Name of Specific Home/Facility: _____

Date of admission: _____ LCD: _____ Reviewed Period: From _____ To _____

OOH Agency Reviewer: _____ Phone #: _____

Clinical Update:

1. What are the **current** target symptoms/behaviors being addressed in this level of care:

2. List each observable, measurable goal being addressed and progress towards its completion. If there are more goals, please list each one and describe the progress.

Goal #1:	
Progress:	
Goal #2	
Progress:	
Goal #3	
Progress	

3. What is the member's current level of functioning? If not documented above, include information on ADLs, interpersonal interactions, school and/or work performance.

Member's Name: _____

4. What interventions [not services] were used during this reporting period to address the current target symptoms and accomplish the above goals?

5. What family involvement occurred during this reporting period? If no family involvement, explain why not.

6. What were the dates and outcomes of the clinical team meetings/CFTs during this reporting period?

7. Current Diagnosis:

Psychiatric Diagnosis: _____

Medical Diagnosis: _____

8. What are the member's current medications:

Psychotropic Medications with directions	Medical Medications with directions

Member's Name: _____

Discharge Planning Update:

1. What is the targeted level of functioning for the member to be considered ready for discharge? This must be observable, measurable terms.

2. How does the member's current level of functioning prevent him/her from returning to the community with outpatient services and supports?

3. How many more days of service are being requested to reach the targeted level of functioning?

4. What is the specific discharge plan? Include the specific living arrangement as well as the planned outpatient services and supports and their frequency after discharge.

5. Are there any barriers to implementing the discharge plan at this time? If yes, list the specific barrier(s) and outline the intervention(s) planned to remove it/them.
