author by Humana

Behavioral Health Inpatient Clinical Review Form

Use this form when gathering information for inpatient precertification or concurrent review authorization with Author by Humana. Please type or print legibly and complete the entire form before submitting. Circle or check responses where applicable.

For any questions, please contact an Author by Humana Provider Navigator at 1-833-502-2013, from 8 AM to 5 PM Eastern time, Monday through Friday.

Member Information

Member Name: _____ Date of Birth: _____

Member ID Number: _____ Date of Request: _____ Date of Admission: _____

Provider Information

Provider/Facility Name: _____ NPI#: _____

UM Reviewer Name: _____ UM Phone: _____

Primary Diagnosis: _____

Secondary Diagnoses: _____

If non-med compliant, involuntary med papers completed? Yes _____ No _____

Family participating in treatment? Yes _____ No _____

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With community health outreach and comprehensive discharge planning, Author by Humana is committed to supporting your patient's behavioral health needs. If you would like to be contacted for more information on behavioral health services, please check "yes" below.

Yes _____ No _____

Current mental status exam and symptoms/behaviors:
Copy and paste from medical records or attach to this form

Treatment plan (including medication changes, relevant medical issues):
Copy and paste from medical records or attach to this form

Discharge plan:
Copy and paste from medical records or attach to this form

Barriers to discharge and plan to address barriers:
(e.g. basic needs, financial expense, benefit issues, transportation, lack of support in community)
Copy and paste from medical records or attach to this form

Estimated Discharge Date: _____

Discharge Planner Name & Phone: _____

Patient (or Guardian) Name & Phone: _____