Harmony HealthCare
Concurrent Review Form

Admission Date: | **Last Covered Day (Date)**

Patient Name | **Date of Birth:** | **Age:**

Home Address: | **City** | **State** | **Zip Code**

Primary Insurance Coverage: | **Insurance Identification #:**

Secondary Insurance Coverage: | **Insurance Identification #:**

Family Contact | **Relationship**

PRIMARY
Specifiers:
(Severe, Moderate)
Features:
(Recurrent, Psychotic)

Diagnosis
Diagnostic Code: _____
DC: 0-3R: _____

Identified Issues:
1. _____
2. _____
3. _____

SECONDARY
Specifiers:
(Severe, Moderate)
Features:
(Recurrent, Psychotic)

Diagnosis
Diagnostic Code: _____
DC: 0-3R: _____

Identified Issues:
1. _____
2. _____

Clinical status since last review (check appropriate box)

- ☐ **Unchanged**
- ☐ **Worse**
- ☐ **Improved**

Evidenced by:

Currently dangerous to self or others: ☐ **YES** ☐ **NO**

Evidenced by:

Currently unable to care for self: ☐ **YES** ☐ **NO**

Evidenced by:

Currently able to plan for safety: ☐ **YES** ☐ **NO**

Evidenced by:

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Patient Name | **Date of Birth:** | **Age:**

Medication changes since LAST review:

Please explain the rationale (medical necessity) for treatment to continue in an inpatient versus an outpatient setting:

Projected Discharge Date | **Attending Physician**

After Care Plan:

Completed by: | **Date**

Title / Position