



Behavioral Health Prior Authorization Form

(Mental health inpatient, mental health partial hospitalization, and mental health intensive outpatient)

Submit to: Behavioral Health Utilization Management

Fax: 1-877-234-4273

For assistance, please call: 1-855-301-5512

Please note: Authorization is based on medical necessity. Incomplete or illegible forms will delay processing. Please provide all pertinent clinical information, including assessments and/or treatment plans. A telephonic review may be required if additional clinical information is needed to determine medical necessity.

Today's date:

REQUESTED SERVICE

<input type="checkbox"/> Mental health inpatient	<input type="checkbox"/> Precertification <input type="checkbox"/> Continued stay	Date of admission: Estimated length of stay:
<input type="checkbox"/> Mental health partial hospitalization	<input type="checkbox"/> Precertification <input type="checkbox"/> Continued stay	Service start date: Number of units per day: Number of days per week: Number of weeks requested:
<input type="checkbox"/> Mental health intensive outpatient	<input type="checkbox"/> Precertification <input type="checkbox"/> Continued stay	Service start date: Number of units per day: Number of days per week: Number of weeks requested:

REQUESTED SERVICE

Name (last, first, MI):		
Date of birth:	Phone number:	Eligibility ID number:
Address:		
Emergency contact:	Phone number:	Relationship:
If dependent adult, legal guardian:		Phone number:

Is this member currently in the PROMISE program? Yes No

Should the member be evaluated for the PROMISE program? Yes No

PROVIDER INFORMATION

Facility name:		
Facility address:		
Facility NPI/tax ID:	Facility phone number:	Facility fax number:
UM review contact name:	Attending physician:	NPI/tax ID:

DIAGNOSES

Primary diagnosis:	Secondary diagnosis:	Tertiary diagnosis:
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MEDICATIONS

Home medications, if known, including dosages and prescriber (e.g., PCP or psychiatrist):				
Name of current treating psychiatrist, if any:				Date last seen:
Medication name	Dosage	Frequency	Date of last change, if applicable	Type of change
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
				<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> D/C <input type="checkbox"/> New
Additional information, if applicable:				

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CURRENT RISK AND LETHALITY

Suicidal: No Yes — please answer questions below.

Active recurrent thoughts: Yes No Making threats: Yes No Plan: Yes No

Available means: No Yes — please explain:

Command hallucinations: No Yes — please explain:

History of suicide attempts: No Yes — please explain:

Homicidal thoughts: No Yes — please explain:

Active recurrent thoughts: Yes No Making threats: Yes No Plan: Yes No

Available means: No Yes — please explain:

Command hallucinations: No Yes — please explain:

History of suicide attempts: No Yes — please explain:

Assault or violence: No Yes — please explain:

History of assault or violence: No Yes — please explain:

MENTAL STATUS EXAM (INCLUDING APPEARANCE, EYE CONTACT, SPEECH, MOTOR ACTIVITY, THOUGHT PROCESS AND CONTENT, ORIENTATION, MOOD, AFFECT, AND HALLUCINATIONS): CHECK ALL THAT APPLY

Appearance	<input type="checkbox"/> Neat	<input type="checkbox"/> Well-groomed	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Dirty	<input type="checkbox"/> Drowsy
	<input type="checkbox"/> Intoxicated	<input type="checkbox"/> Casual			
Eye contact	<input type="checkbox"/> Adequate	<input type="checkbox"/> Intense	<input type="checkbox"/> Staring	<input type="checkbox"/> Avoidant	<input type="checkbox"/> Guarded
	<input type="checkbox"/> Poor	<input type="checkbox"/> Other:			
Speech	<input type="checkbox"/> Normal	<input type="checkbox"/> Soft	<input type="checkbox"/> Loud	<input type="checkbox"/> Slowed	<input type="checkbox"/> Slurred
	<input type="checkbox"/> Pressured	<input type="checkbox"/> Repetitive			
Interaction	<input type="checkbox"/> Pleasant	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Angry	<input type="checkbox"/> Guarded	<input type="checkbox"/> Suspicious
	<input type="checkbox"/> Apathetic	<input type="checkbox"/> Aloof	<input type="checkbox"/> Passive		
Motor activity	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Restless	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Repetitive	<input type="checkbox"/> Agitated
Affect	<input type="checkbox"/> Full range	<input type="checkbox"/> Flat	<input type="checkbox"/> Blunted	<input type="checkbox"/> Labile	<input type="checkbox"/> Constricted
	<input type="checkbox"/> Tearful	<input type="checkbox"/> Inappropriate			
Mood	<input type="checkbox"/> Calm	<input type="checkbox"/> Anxious	<input type="checkbox"/> Depressed	<input type="checkbox"/> Manic	<input type="checkbox"/> Hostile
	<input type="checkbox"/> Sad	<input type="checkbox"/> Euphoric			
Thought process	<input type="checkbox"/> Coherent	<input type="checkbox"/> Goal directed	<input type="checkbox"/> Blocking	<input type="checkbox"/> Loose associations	<input type="checkbox"/> Tangential
Thought content	<input type="checkbox"/> Coherent	<input type="checkbox"/> Suicidal	<input type="checkbox"/> Homicidal	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Grandiose
	<input type="checkbox"/> Delusional				
Orientation	<input type="checkbox"/> Oriented	<input type="checkbox"/> Person	<input type="checkbox"/> Place	<input type="checkbox"/> Time	<input type="checkbox"/> Disoriented

PRESENTING PROBLEM/CURRENT CLINICAL

Current clinical (SI, HI, psychosis, mood or affect, sleep, appetite, withdrawal symptoms, chronic substance use disorder [SUD]):

Describe member's functioning:

Activities of daily living (ADLs):

Social settings:

Education and occupation:

Current living environment:

Indicate the recommendations of the member's assessment or evaluation and treatment plan:

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TREATMENT HISTORY AND CURRENT TREATMENT PARTICIPATION

Previous mental health/SUD inpatient, rehabilitation, and detox:
Outpatient treatment, psych testing, crisis intervention, community-based services:
Is the member participating in individual or group therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Explain the member's clinical treatment plan:
How long has the member experienced mental illness and/or an SUD?
Family involvement or support system:
Substance use: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes and the member is in mental health inpatient, please explain how the SUD is being treated:

DISCHARGE PLANNING

Discharge planner name:	
Phone number:	Fax number:
Place of residence upon discharge:	
Address:	
Treatment setting and services upon discharge:	
Provider of services, if known:	
Has a post-discharge seven-day follow-up aftercare appointment been scheduled? <input type="checkbox"/> Yes (complete below)	
Provider name:	Date and time of appointment:
<input type="checkbox"/> No — please explain:	
Identify collaboration needs. Please indicate if collaboration is needed with any of the below, including contact name and phone number:	
<input type="checkbox"/> PROMISE program:	
<input type="checkbox"/> Child or adult protective agency:	
<input type="checkbox"/> Group home:	
<input type="checkbox"/> Nursing or nursing home facility:	
<input type="checkbox"/> Residential program:	
<input type="checkbox"/> Jail, prison, or court system:	
<input type="checkbox"/> LTSS or waiver programs:	
<input type="checkbox"/> Other:	
Provider signature:	
Date:	