

Behavioral Health Authorization Request Form

 <p>Fax #: 808-973-6324 Phone #: 808-973-0712 Website: https://www.alohacare.org</p>	 <p>An Independent Licensee of the Blue Cross and Blue Shield Association Fax #: 808-695-7799 or 855-539-5880 Phone #: 808-695-7700 (local) or 855-856-0578 Website: https://prc.hmsa.com/s/</p>	 <p>Medicaid PHP/IOP Fax: 855-550-8977 Medicaid OP Fax: 888-481-9739 Medicaid SRT/ECT Fax: 888-890-8219 Phone #: 888-846-4262 (Medicaid) Website: www.ohanahealthplan.com CCS SMI Referrals call: 888-846-4262</p>	 <p>Fax #: 1-877-840-5581 Phone #: 1-888-980-8728 Retrospective Review: Phone: 866-556-8166 Fax: 855-312-1470 Website: www.ProviderExpress.com</p>
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<input type="checkbox"/> Standard request	Medicaid plans: decision & notification are made within 14 calendar days* For HMSA Commercial, Federal and EUTF plans: decisions & notification are made within 15 calendar days*
<input type="checkbox"/> Expedited request <i>(Licensed provider signature required)</i>	Decision & notification are made within 72 hours* or as expeditiously as this member's health condition requires if urgent criteria are met. <i>By signing below, I certify that following the standard timeframe could seriously jeopardize this member's life or health or ability to attain, maintain, or regain maximum function.</i>
Signature (if left blank, request will be reviewed based on standard timeframes) _____ Date signed _____	
<input type="checkbox"/> Retrospective	Retrospective authorization is defined as a request for services that have been rendered but a claim has not been submitted.

**From receipt of request, provided that all relevant supporting clinical information and documentation are submitted.*

To avoid delays, please attach supporting documents. (See below for a list of recommended supporting clinical documentation)

A. Member information

Membership number	Members name (last, first, MI)	Date of birth MM/DD/YYYY
Member's Physical Address	Phone no.	

B. ICD-10-CM diagnosis code(s)

Diagnosis code(s): _____

C. Procedure/service/treatment information

Level of Care: Outpatient Intensive Outpatient Programming Partial Hospitalization
 Residential Treatment Center Acute Inpatient

Place of Service: 11- Office 22- Outpatient Hospital 52- Psychiatric Facility-Partial Hospitalization
 53- Community Mental Health Center 55- RTC

Treatment Focus: Mental Health Substance Use Disorder -Please specify ASAM Level of Care: _____ Dual Diagnosis
 Last Date of Service: _____ Total Visits Used _____ Detox-WM

CPT/HCPCS/REV code(s)	Total # of Days/Units/Visits	CPT/HCPCS/REV code(s)	Total # of Days/Units/Visits

Service date(s): _____ to _____ Continuation of Care / Transition of Care

D. Provider information

Requesting (or referring) provider name	Participating Provider ID Number	
Address		
Contact Name	Phone No.	Fax No.
Servicing Provider/Facility/Vendor (if different from requesting or referring provider)		Provider ID/NPI/TIN
Is facility accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No If accredited: <input type="checkbox"/> CARF <input type="checkbox"/> JCAHO		
Address		
Contact Name	Phone No.	Fax No.

Behavioral Health Clinical Documentation Checklist

As part of a Stepped Approach to delivering effective behavioral health services, all Health Plans utilize the American Society of Addiction Medicine (ASAM) criteria and/or other nationally recognized assessment and placement tools that reflect evidence-based clinical guidelines. Clinical documentation received from providers are carefully reviewed to support the review process and to ensure that members are receiving the most appropriate care based on their strengths and presenting needs. The informational checklist below is intended as a guide for preparing the required documentation for services requiring Prior Authorization. While not all the information below will be relevant to all services, Providers are encouraged to focus on those elements which are applicable to the service being requested.

Recommended Clinical Information – Initial Review (typically all included in the assessment/evaluation)

- Clinical information compiled from the member and all available sources to determine member is appropriate for the specific Level of Care. The initial evaluation must contain the following information:
 - The member’s chief complaint and include member’s understanding of the factors that lead to requesting services (i.e. the “why now” factors)
 - The history of the presenting illness
 - Mental status evaluation
 - The member’s current level of functioning
 - Urgent needs including those related to the risk of harm to self, others, or property
 - Psychiatric and medical histories including the histories of substance use, abuse and trauma
 - Co-occurring behavioral health and physical conditions
 - The member’s history of behavioral health treatment
 - Pertinent current and historical life information including the member’s: age, gender, sexual orientation, culture, spiritual beliefs, educational history, employment history, living situation, legal involvement, family history, relationships with family, friends and others.
 - The member’s strengths
 - Barriers to care
 - Member’s instructions for treatment or appointment of an agent to make treatment decisions
 - The member’s broader recovery, resiliency and wellbeing goals
- Initial program assessments demonstrating member’s level of care must be submitted with the initial request
- Clinical information to be included at initial review for SUD services: (matches ASAM dimensions)
 - Precipitating event
 - Urine drug screen/blood alcohol level
 - History of substance use (substance(s), amount, frequency, age of first use, last use)
 - Substance use treatment history
 - Longest period of abstinence
 - Triggers for use
 - Stage of change
 - Current withdrawal symptoms (if applicable)
 - COWS/CIWA score (if available)
 - Vitals (for inpatient only)
 - Medications
 - Detox protocol being used
 - Medical history
 - Psychiatric history

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- Family history of substance use or mental health issues
- Support system
- Legal issues
- Education/employment

Recommended Clinical Documentation – Treatment Plan (initial and continued stay reviews)

- The short- and long-term goals of treatment;
- The expected outcomes for each problem that are measurable, functional, time-framed and relevant
- How the member's family and other natural resources will participate in treatment when indicated
- How treatment will be coordinated with other providers, agencies or programs
- Includes interventions that further engage the member in treatment that promote the member's participation in care, promote informed decisions and support the member's broader recovery and resiliency goals.
- Treatment focuses on the "why now" factors to the point that the member can be safely treated in a less intensive level of care or treatment is no longer required
- The provider informs the member of safe and effective alternatives, potential risks and benefits
- A change in the member's condition prompts a reassessment of the treatment plan and re-evaluation

Recommended Clinical Documentation – Continued Stay Review

- Individual counseling for evaluation of the treatment and whether changes in the treatment plan are needed at least 2 times per week for Residential and at least weekly for PHP
- Updated daily clinical information reflecting active treatment is being delivered
- Clinical best practices are being provided timely with sufficient intensity to address the member's treatment needs and reasonably expected to stabilize the member's condition and/or the precipitating factors
- The member's family and other natural resources are engaged to participate in the member's treatment as clinically indicated.
- Clinical information to be included at concurrent review for SUD services:
 - Urine drug screen/blood alcohol level
 - Problem statement from treatment plan
 - Primary treatment goal (include target and completion dates)
 - Objectives (include target and completion dates)
 - Interventions
 - Stage of change
 - Progress or non-progress (as evidenced by)
 - Discharge plan
 - Barriers to community tenure