Behavioral Health Prior Authorization Form

Please print clearly. Incomplete or illegible forms will delay processing. Please fax completed form to AmeriHealth Caritas Iowa Behavioral Health (BH) Utilization Management (UM) at **1-844-214-2469**.

For assistance, please call **1-844-214-2474**.

Today's date: ______________________ Date of admission/service start: ______________________

Please note: Authorization is based upon medical necessity. Please present all clinical information and attach assessments or treatment plans as applicable.

Type of review:	☐ Precertification	☐ Continued stay	Estimated length of stay: ________ (days/units)
Type of admission:	☐ Mental health — inpatient (MH-IP) ☐ Subacute IP ☐ Intensive psych rehab ☐ MH partial hospitalization program (PHP)/intensive outpatient program (IOP) Insert service code:________	☐ Substance use (SU) rehab ☐ SU detox ☐ SU halfway house Insert service code:______	☐ SU PHP/day treatment ☐ SU IOP Insert service code:________
Admission status:	☐ Voluntary	☐ Involuntary commitment	Readmission within 30 days? ☐ Yes ☐ Unknown

Member information

Last, first, MI: ______________________ Date of birth: __________

Address: ______________________ Eligibility number: ______________________

Emergency contact (other than primary caregiver): ______________________ Phone: ______________

Legal guardian/parent: ______________________ Phone: ______________

Provider information

Facility/provider name: ______________________ NPI/tax ID: ____________ Provider ID: ____________

Address: ______________________ Attending M.D.: ______________________

UM review contact: ______________________ Phone: ______________________

DSM-5 diagnosis (include mental health, substance use and medical): ______________________

For members age 21 and under: has a Certificate of Need been completed? ☐ Yes ☐ No ☐ N/A

If yes, please attach to form. If no, please explain: ______________________

Please note that for all BH IP admissions for members age 21 and under, a Certificate of Need (CON) must be submitted to AmeriHealth Caritas Iowa by close of business the same day a request is submitted.

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Medications				
Med name	**Dosage**	**Frequency**	**Date of last**	**Type of change**
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
Additional information:				

Current risk/lethality					
Suicidal	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme
Homicidal	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme
Assault/violence	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme
Mental status exam (mood, affect, hallucinations):					

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Presenting problem/current clinical update (SI, HI, psychotic, mood/affect, sleep, appetite, withdrawal symptoms, chronic SU):

Please describe the member's functioning below.

☐ Activities of daily living (ADLs):______________________________

☐ Social settings:______________________________

☐ Educational/occupational:______________________________

☐ Current living environment:______________________________

Please indicate below the recommendations of the member's biopsychosocial assessment and treatment plan.

____

Treatment history and current treatment participation

Previous MH/SU IP, rehab, detox:______________________________

Outpatient treatment, psych testing, crisis intervention, CSS/BHIS, habilitation history

____

Is the member currently attending therapy and groups? ☐ Yes ☐ No

Explain clinical treatment plan:______________________________

How long has the member experienced mental illness and/or substance use disorder?______________________________

Family involvement/support system: ______________________________

Substance use: ☐ Yes ☐ No
If yes, MH services only? Please explain how substance use is being treated.

____

Please complete below for current American Society of Addiction Medicine (ASAM) dimensions and/or submit with documentation for all substance use services. ASAM is required to determine medical necessity criteria. This includes SU IOP, PHP/day treatment, SU detox, SU rehab, SU halfway house and SU peer support services. If the service is mental health only and does not require ASAM criteria, please skip to the "discharge planning" section.

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Dimensions rating (0 – 4)	**Current ASAM dimensions required**			
Dimension 1: Acute intoxication and/or withdrawal potential Rating: ________	Substances used (pattern, route, last used):	Tox screen completed? ☐ Yes ☐ No If yes, results:	History of withdrawal symptoms:	Current withdrawal symptoms:
Dimension 2: Biomedical conditions and complications Rating: ________	Vital signs:	Is member under doctor care? ☐ Yes ☐ No Current medical conditions:	History of seizures? ☐ Yes ☐ No	
Dimension 3: Emotional, behavioral or cognitive conditions and complications Rating: ________	MH diagnosis:	Cognitive limits? ☐ Yes ☐ No	Psych medications and dosages:	Current risk factors (SI, HI, psychotic symptoms):
Dimension 4: Readiness to change Rating: ________	Relapse prevention skills:	Internal or external motivation:	Stage of change, if known:	Legal problems/ probation officer:
Dimension 5: Relapse, continued use or continued problem potential Rating: ________	Relapse prevention skills:	Current assessed relapse risk level: ☐ High ☐ Moderate ☐ Low	Longest period of sobriety:	
Dimension 6: Recovery/living environment Rating: ________	Living situation:	Sober support system:	Attendance at support group:	Issues that impede recovery:

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Discharge planning:

Discharge planner name and contact:______________________________

Residence address upon discharge:______________________________

Treatment setting and provider upon discharge:

____

Has a post-discharge seven-day follow-up aftercare appointment been scheduled? ☐ Yes ☐ No

If no, please explain:______________________________

If yes, please provide treatment provider name, date and time of scheduled follow-up:

____

Collaboration needs: please indicate if collaboration is needed with any of the below, including contact name and phone number.

☐ Juvenile justice: ______________________________

☐ Child or adult protective agency:______________________________

☐ School system:______________________________

☐ Nursing or nursing home facility:______________________________

☐ Residential program:______________________________

☐ Jail/prison/court system:______________________________

☐ Other:______________________________

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Provider signature:______________________________ Date:____________________