Behavioral Health Intervention Service (BHIS) Authorization Request Form

BHIS providers or licensed practitioners of the healing arts (LPHA) must use this form to request authorization for BHIS.

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**.

Member Information	
Member name:	Date of birth:
Medicaid/health plan number:	
Last authorization number (if applicable):	Parent/legal guardian:

Requesting Provider Information (if different from the BHIS provider indicated below)	
Provider name and title:	Phone number:

BHIS Provider Information	
Provider name:	☐ In-network ☐ Out-of-network ☐ In credentialing process
Group name:	Provider credentials:
Physical address:	
Phone number:	Fax number:
Medicaid/provider/NPI number:	Contact name and title:

DSM diagnosis: primary DX _____ secondary DX _____ medical DX _____

BHIS treatment request (check all that apply): Start date: _____ Estimated end date: _____

☐ Behavior intervention individual skills (age 0-20). Service code: H2019 HA at _____ units per week

☐ Behavior intervention group skills (age 0-20). Service code: H2019 HQ at _____ units per week

☐ Family training (age 0-20). Service code H2019HR at _____ units per week

Curriculum used: _____

☐ BHIS foster group care (age 0-20). Service code: H0019 at _____ days per week

☐ Individual skill training and development (age 18+). Service code: H2014 HB at _____ units per week

☐ Group skill training and development (age 18+). Service code: H2014 HQ at _____ units per week

Please note: Crisis intervention for members aged 20 and under does not require a prior authorization. Crisis intervention does require notification to AmeriHealth Caritas Iowa within two business days post service for providers to obtain an authorization number.

Per the Iowa Administrative Code 441.78.12 the member must be actively involved in a treatment plan with a licensed practitioner of the healing arts (LPHA). All members must have an assessment completed by a LPHA who recommends BHIS as part of the overall treatment plan. In addition, members under the age of 21 are required to have a standardized assessment instrument as part of the clinical assessment. BHIS family training also must be based on a curriculum with a training manual.

BHIS providers are required to develop a service implementation plan based on the needs outlined in the LPHA assessment to guide BHIS services. Please reference the AmeriHealth Caritas Iowa BHIS UM Guidelines for more information.

Please include the member's recent assessment and treatment plan completed by a LPHA when submitting this BHIS authorization request form.

- Recent assessment (within six months of date of request) completed by the LPHA. The assessment must include all of the following elements that are applicable to the member:
  - Presenting problem/current symptoms/behaviors to include current risk/lethality.
  - Reason for requested services.
  - Social/medical/psychiatric history.
  - Current and previous treatment history and compliance with treatment within last 12 months.
  - Current or previous waiver services (if applicable).
  - Current and previous court-ordered treatment services.
  - Assessor, credential, contact information.
  - Current medications and compliance with medications.
  - Diagnoses.

  If the assessment does not include all of these elements, please submit documentation that does.

- Treatment plan: the member's current treatment plan with a LPHA.

The standardized assessment tool completed by the LPHA (for members aged 21 and under): _____

Results of assessment tool: _____

BHIS service implementation plan: Please clearly indicate the BHIS service (e.g., BHIS individual, BHIS family, etc.) and what interventions (e.g. anger management, social skills, etc.) will be provided under each service requested. Please specify for each intervention the duration and frequency of delivery per week (e.g., 30-minute sessions twice per week) and the number of weeks needed to complete one cycle of intervention (e.g. social skill training lasts 12 weeks, relaxation training and practice sessions last eight weeks, etc.).

Problem/goal	BHIS service	Type of intervention	Duration (minutes) and frequency (sessions per week)	Length of intervention (weeks needed to complete one cycle)

Reason for authorization of out-of-network providers

(BHUM will contact provider directly before giving an authorization.)

☐ N/A, provider is in-network
1. Specialty of provider to meet the needs of the member:
2. Continuity of care concerns:
3. Accessibility/availability of provider:
4. Clinical rationale:

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: _____