Mental Health and Substance Use Disorder Authorization Request

Use this form to request authorization for Applied Behavior Analysis (ABA), Community Support, and Assertive Community Treatment (ACT).

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**.

Important Note: Mental health and substance use disorder peer support services no longer require prior authorization.

Member information	
Patient name:	Date of birth:
Medicaid/health plan number:	Last authorization number (if applicable):

Requesting provider information	
Provider name and title:	Phone number:

Treating provider information	
Provider name:	☐ In-network ☐ Out-of-network ☐ In credentialing process
Group/agency name:	Provider credentials: ☐ M.D. ☐ Ph.D. ☐ LMHP ☐ LAC ☐ Other, please specify:
Physical address:	Phone number: Fax number:
Medicaid/provider/NPI number:	Contact name and title:

DSM diagnosis
Primary DX: Secondary DX: Medical DX:

Primary care provider (PCP) and other communication
Has information been shared with the PCP/other providers regarding:

1. The initial evaluation and treatment plan? ☐ Yes ☐ No
2. The updated evaluation and treatment plan? ☐ Yes ☐ No

Other behavioral health providers' names and last notified:____________________________________

PCP name and date last notified:____

If no, please explain:____

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

Medications	
Is member prescribed medications? ☐ Yes ☐ No	Prescribing physicians' names:
Is member compliant with medications? ☐ Yes ☐ No	Please list medications and dosages:

Court-ordered treatment services (past or present): ☐ Yes ☐ No
If yes, give specifics:

Please include the member's recent assessment and treatment plan			
List primary complaint/problem to address:			
Overall progress toward goals:	☐ 1 None/Min	☐ 2 Moderate	☐ 3 Met
List measurable treatment goals:			
Compliance with treatment:	☐ 1 None/Min	☐ 2 Moderate	☐ 3 Met

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Authorization request: ☐ **Community support** ☐ **ACT** ☐ **ABA**

Reason for authorization of NON-PAR providers (Utilization Management will contact provider directly before giving an authorization):

☐ NA; 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: ______________________________

Total sessions requested: Frequency of visits: CPT/HCPC Codes: Start date: Estimated end date:

Member symptoms (please check all that apply)

- ☐ Adult: serious and persistent mental illness (SPMI)
- ☐ Child: serious emotional disturbance (SED)
- ☐ Developmental disability disorder
- ☐ Medically stable
- ☐ Lack of natural supports for member or for family
- ☐ Inadequate skills to find and/or utilize resources
- ☐ Anxiety
- ☐ Depression
- ☐ Inattention
- ☐ Substance use disorder: actively using
- ☐ Substance use disorder: pursuing a recovery plan
- ☐ Confusion
- ☐ Psychosis/hallucinations
- ☐ Bizarre behavior
- ☐ Unprovoked physical or verbal agitation/aggression
- ☐ Self-injurious behavior
- ☐ Behaviors that pose serious risk to self or others
- ☐ Withdrawn/poor social interaction
- ☐ Mood instability
- ☐ Inability to perform ADL
- ☐ Obsessions and/or compulsions
- ☐ Changes in memory capacity
- ☐ Changes in cognitive capacity
- ☐ Behavior problems affecting life functions (e.g., school, home, work)
- ☐ Poor academic or employment performance due to mental health/ substance use disorder
- ☐ Hyperactivity
- ☐ Hypoactivity
- ☐ Other, provide specifics:

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Previous treatment history: ☐ None **or**

Service type/ level of care	Dates/year of participation	# of attempts at this level of care	Service type/ level of care	Dates/year of participation	# of attempts at this level of care
☐ MH/SU OPT			☐ Community support services		
☐ MH/SU IOP			☐ Habilitation program services		
☐ MH/SU IP			☐ Applied Behavior Analysis		
☐ Behavioral Health Intervention Services			☐ Psychiatric Medical Institution for Children		
☐ Intensive Psychiatric Rehabilitation			☐ Iowa Department of Public Health		
☐ Integrated Health Home			☐ Peer support		
☐ Electro-convulsive therapy			☐ Other:		
☐ Assertive Community Treatment			☐ SUD residential		

Previous or current waiver services: ☐ Yes ☐ No

If yes, give specifics:

Additional comments/information:

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Services: Please indicate all services being requested.

1. Applied Behavior Analysis (ABA)
   ☐ Direct Applied Behavior Analysis H2019 HO/HP and HN
   ☐ Home care training; insert code____________

2. Applied behavior analysis: Please include the member's treatment plan with the authorization request.
   Additional questions required for all ABA requests:
   - Is the child diagnosed with autism spectrum disorder?
     ☐ Yes ☐ No
   - Indicate the tool used to make this diagnosis:
     ____
   - Is the child older than 18 months?
     ☐ Yes ☐ No
   - Does the child have deficiencies in communication and social interactions in two different settings?
     ☐ Yes ☐ No
     If yes, indicate the two settings:
     ____
   - Does the child have repetitive/restricted behaviors?
     ☐ Yes ☐ No
   - Is the child diagnosed or suspected of having a severe intellectual disability?
     ☐ Yes ☐ No
     If yes, explain: ________________________________
   - What is the child's estimated IQ?
     ____
   - Is the child deaf or blind? ☐ Yes ☐ No
   - Has the behavior analyst coordinated with the child's school, preschool or early intervention program?
     ☐ Yes ☐ No
   - Indicate ABA intensity/frequency:
     ____

3. Community support services for adults:
   ☐ H0037 low intensity
   ☐ H0037-TF high intensity

4. Assertive community treatment (ACT): ☐ H0040

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:__________________________