Outpatient Authorization Request (OAR)

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**.

In-network providers: Prior authorization is only required for the following services: Electroconvulsive Therapy (90870)*, Unlisted Psychiatric Services (90889), Environmental Interventions (90882) and Psychological Testing (on a separate form).
*Electroconvulsive therapy (ECT) services must be prior authorized by telephonic review. Please call **1-844-214-2474**.

Out-of-network providers: Prior authorization and a noncontracted provider form are required for all services.

Member information

Patient name: _____ Date of birth: _____

Medicaid/health plan number: _____ Last authorization number (if applicable): _____

Provider information

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

Type of request: ☐ Initial ☐ Continued stay

Previous or current MH/SU treatment: ☐ None **or** ☐ MH/SU OPT ☐ SU IOP ☐ MH/SU IP ☐ MH/SU residential
☐ BHIS ☐ IPR ☐ Integrated health home ☐ Community support services ☐ Habilitation program services
☐ ABA therapy ☐ PMIC ☐ IDPH SUD ☐ Peer support
☐ Other (provide specifics): _____

Substance use: ☐ None ☐ By history ☐ Current/active

Tobacco use: ☐ None ☐ By history ☐ Current/active

Substances used, amount, frequency and last used: _____

Previous or current waiver services: ☐ Yes ☐ No
If yes, give specifics: _____

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:_____

Is the member's family and support system involved in treatment planning and treatment? ☐ Yes ☐ No
(If no, explain): _____

Was the member given a choice in their behavioral health/substance use provider? ☐ Yes ☐ No
(If no, 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:

Treatment plan and goals			
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

Authorization request: ☐ **Individual** ☐ **Group** ☐ **Family** ☐ **Med management** ☐ **ECT (call BH UM for PA)**
Reason for authorization of out-of-network 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:
_____	_____	_____	_____	_____

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: _____