BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST

Aetna Better Health of Kansas
9401 Indian Creek Parkway, Suite1300
Overland Park, KS 66210
Telephone Number: 1-855-221-5656
Fax Number: 1-855-225-4102
TTY: 711

Date of Request (MMDDYYYY):

Did you know that you can use our provider portal Availity® to submit prior authorization request, upload clinical documentation, check statuses, and make changes to existing requests? Register today at www.Availity.com

SERVICE TYPE: ☐ PSYCHOLOGICAL / NEUROPSYCHOLOGICAL ☐ APPLIED BEHAVIOR ANALYSIS (ABA)

☐ ELECTROCONVULSIVE THERAPY (ECT) / TRANSCRANIAL MAGNETIC STIMULATION (TMS)

☐ OUTPATIENT TREATMENT REQUEST (OTR)

☐ URGENT – When a non-urgent prior authorization request could seriously jeopardize the life or health of a member. The member's ability to attain, maintain, or regain maximum function or that a delay in treatment would subject the member to severe pain that could not be adequately managed without the care/service requested. Urgent requests will be processed within 72 hours.

☐ NON - URGENT STANDARD – Routine services processed within 14 days.

Visit our ProPAT search tool to determine if a service requested requires PA https://medicaidportal.aetna.com/propat/Default.aspx. A determination will be communicated to the requesting provider.

COMPLETE SECTIONS 1-3 IN THEIR ENTIRETY.

SECTION 1 - MEMBER INFORMATION			
1. FIRST NAME	2. M.I.	3. LAST NAME	
4. MEDICAID ID#	5. DATE OF BIRTH (MMDDYYYY)	6. MEMBER PHONE # (xxx-xxx-xxxx)	
7. DOES THE MEMBER HAVE OTHER INSURANCE? (Include Policy Number Below)			
SECTION 2 ORDERING/REFERRING & SERVICING PROVIDER INFORMATION			
8. ORDERING/REFERRING PROVIDER NAME		9. CONTACT PERSON (For questions)	
10. TELEPHONE # (xxx-xxx-xxxx)	11. FAX # (xxx-xxx-xxxx)	12. NPI	
13. SERVICING PROVIDER NAME / FACILITY / AGENCY		14. CONTACT PERSON (For questions)	
15. TELEPHONE # (xxx-xxx-xxxx)	16. FAX # (xxx-xxx-xxxx)	17. NPI	
SECTION 3 – DIAGNOSIS CODES AND SERVICE / HCPCS CODES			
18. SERVICE START DATE (MMDDYYYY)		19. SERVICE END DATE (MMDDYYYY)	
20. ICD 10 / DSM 5 CODE(S)	21. CODE DESCRIPTION(S) Include description of the service when uncertain of a code.		

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22. CPT / HCPCS / REV CODES:	23. CODE DESCRIPTION(S):	24. QUANTITY / UNITS:

COMPLETE THE SECTION WHICH CORRESPONDS TO THE SERVICE AUTHORIZATION BEING REQUESTED.

NOTE: SECTION 8 "ATTESTATION" MUST BE COMPLETED FOR ALL REQUESTS

SECTION 4 – ECT / TMS REQUEST
Complete all fields in their entirety.

25. TREATMENT REQUEST FOR:
Initial ☐ Concurrent ☐

26. PLACE OF SERVICE (If inpatient, why?):

27. PRIOR ECT TREATMENT?
Yes ☐ No ☐

28. INFORMATION CONSENT OBTAINED? (If applicable):
Yes ☐ No ☐

29. SUBSTANCE ABUSE HISTORY?
Yes ☐ No ☐

30. ATTENDING PYSCHOTHERAPY?
Yes ☐ Frequency: _____ No ☐

31. KNOWN SEIZURE HISTORY / CONTRAINDICATIONS TO ECT?

32. KNOWN REACTION TO ANESTHESIA, OR MEDICAL COMP L ICATION TO ECT?

33. TARGET SYMPTOMS?

34. AREAS OF CONCERN (Select all that apply)

Presence of cognitive disorder ☐

Presence of significant personality disorder ☐

Lack of housing or family/social support for transition from IP ECT to OP ECT ☐

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Include the following clinical documentation with the ECT/TMS Prior Authorization Request:

- Recent comprehensive Psychiatric Evaluation
- History of Psychiatric Treatment to date (include all levels of care)
  - Include onset, course, and severity of illness
  - Response to treatment
  - Describe Patient's overall treatment compliance
- For prior ECT treatment, include dates, location, number of treatments, results and known contraindications to ECT
- Substance abuse history and current status
- Any labs/diagnostic tests available to the prescribing clinician

SECTION 5 – PSYCHOLOGICAL / NEUROPSYCHOLOGICAL TESTING REQUEST
Complete all fields in their entirety.

35. SERVICE TYPE REQUESTED
Psychological ☐ Neuropsychological ☐

36. PRIOR TESTING? (If yes, include date)
Yes ☐ DATE (MMDDYYYY): No ☐

37. CURRENT BH OUTPATIENT SERVICES?
Yes ☐ No ☐

38. PSYCHIATRIC DIAGNOSTIC EVALUATION?
Yes ☐ No ☐

39. WHAT IS THE CLINICAL QUESTION TO BE ANSWERED BY TESTING?

40. HOW WILL TESTING AFFECT MEMBER'S TREATMENT?

41. DETAILED CLINICAL SUMMARY FROM TREATING PSYCHIATRIC PROVIDER FOR 6 MONTHS:

Include the following documentation with the Psychological/Neuropsychological Prior Authorization Request:

- Detailed clinical summary (Physical & Behavioral Health)
- BHMP Evaluation & progress notes that detail assessment of clinical concern
- Any supporting rating scales
- Neurological assessment reviewed by BHMP (if request is for a Neuropsychological Evaluation)
- Any prior testing completed

SECTION 6 – APPLIED BEHAVIORAL ANALYSIS (ABA)
Complete all fields in their entirety.

42. REQUEST TYPE?
Initial ☐ Concurrent ☐
If concurrent, how long has member been receiving services?

43. TREATMENT SETTING?

44. CLINICAL SYMPTOMS OR SOCIAL BARRIERS?

45. DISCHARGE PLAN (Anticipated date to transition to lower level of care)

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SECTION 7 – OUTPATIENT TREATMENT REQUEST (OTR) REQUEST
Complete all fields in their entirety.

46. REQUEST TYPE?	47. SERVICE TYPE?
Initial ☐ Concurrent ☐	Substance Use Order ☐ Mental Health ☐

48. Clinical Symptoms or Social Barriers?

49. Discharge Plan (Anticipated date to transition to lower level of care):

50. Substance Abuse and/or Mental Health History – History and Current Status:

51. Criteria/Level of Care Utilized in Past 12 Months:

Criteria/Level of Care	Name of Provider	Duration	Approximate Dates (MMDDYYYY - MMDDYYYY)	Outcome

52. OPTIONAL SPACE FOR ADDITIONAL DOCUMENTATION:

Include the following documentation with the ABA Request or OTR Prior Authorization Request:

- Clinical data (Psycho/Social/Behavioral history, mental status, current specific maladaptive behaviors and/or skill deficits, co-occurring disorders, and medical condition(s)
- Progress reducing target behaviors/skill deficits or lack of, and plan to address. For initial ABA requests, include progress or lack-of, with any previous treatment interventions
- Compliance with treatment and treatment recommendations, include plan to address non-compliance
- For ABA Requests, include treatment plan

SECTION 8 – ATTESTATION
Complete all fields in their entirety.

53. Printed Name of Provider/Clinician:	54. Date (MMDDYYYY):

55. Signature of Provider/Clinician:

NOTE: This form must be completed in its entirety in order to receive a determination. Incomplete forms may lead to delays in processing or lack of authorization.

AUTHORIZATION DOES NOT GUARANTEE PAYMENT. ALL AUTHORIZATIONS ARE SUBJECT TO MEMBER ELIGIBILITY ON THE DATE OF SERVICE. TO ENSURE PROPER PAYMENT FOR SERVICES RENEDERED; PROVIDER/FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE.