BEHAVIORAL HEALTH ACUTE AND RESIDENTIAL PRIOR AUTHORIZATION REQUEST

FAX TO: 833-923-0829 TELEPHONE: 844-365-4385

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Telephone Number: 844-365-4385
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Date of Request

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:

- ☐ ACUTE MENTAL HEALTH INPATIENT
- ☐ SUBSTANCE USE RESIDENTIAL TREATMENT
- ☐ PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

☐ 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 24 hours.

☐ NON - URGENT STANDARD – Routine services processed within 72 hours.

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 1-4 IN THEIR ENTIRETY

NOTE: SECTION 7 "ATTESTATION" MUST BE COMPLETED FOR ALL REQUESTS

SECTION 1 – MEMBER INFORMATION		
FIRST NAME:	**MI:**	**LAST NAME:**
MEMBER AETNA ID #: (*REQUIRED*)	**DATE OF BIRTH:** (MMDDYYYY) (*REQUIRED*)	**MEMBER PHONE # (XXX-XXX-XXXX):**
DOES THE MEMBER HAVE OTHER INSURANCE? (Include Policy Number Below)		

SECTION 2 – ORDERING/REFERRING & SERVICING PROVIDER INFORMATION		
ORDERING/REFERRING PROVIDER NAME	**CONTACT PERSON** (For questions)	
TELEPHONE # (xxx-xxx-xxxx)	**FAX #** (xxx-xxx-xxxx)	**NPI**
SERVICING PROVIDER NAME / FACILITY / AGENCY	**CONTACT PERSON** (For questions)	
TELEPHONE # (xxx-xxx-xxxx)	**FAX #** (xxx-xxx-xxxx)	**NPI**

SECTION 3 – DIAGNOSIS CODES AND SERVICE / HCPCS CODES	
SERVICE START/ADMISSION DATE (MMDDYYYY)	
ICD 10 / DSM 5 CODE(S)	**CODE DESCRIPTION(S):** Include description of the service when uncertain of a code

CPT / HCPCS / REV CODES WITH MODIFIER(S):	CODE DESCRIPTION(S):	QUANTITY / UNITS:

	ASAM LEVELS			
	ASAM LOC	**CODE DESCRIPTION**	**CODE**	**UNITS/DAYS REQUESTED**
☐	3.1	HALFWAY HOUSE SERVICES	H2034 HF	
☐	3.1	HALFWAY HOUSE SERVICES, ADOLESCENT	H2034 HF HA	
☐	3.1	HALFWAY HOUSE SERVICES, PREGNANT WOMAN	H2034 HF HD TF	

	ASAM LEVELS			
	ASAM LOC	**CODE DESCRIPTION**	**CODE**	**UNITS/DAYS REQUESTED**
☐	3.1	HALFWAY HOUSE INDV. WITH DEP CHILDREN	H2034 HF HD	
☐	3.3	RESIDENTIAL TREATMENT, CO-OCCURRING	H0019 HH U1	
☐	3.5	RESIDENTIAL TREATMENT	H0019 HF U1	
☐	3.5	RESIDENTIAL TREATMENT, ADOLESCENT	H0019 HF HA U1	
☐	3.5	INTENSIVE RESIDENTIAL TREATMENT (ADULT)	H0019 HF TF	
☐	3.5	RESIDENTIAL TREATMENT, PREG WOMAN/INDV WITH DEP CHILDREN	H0019 HF HD U1	
☐	3.5	INTENSIVE RESIDENTIAL TREATMENT, PREG WOMAN/INDV WITH DEP CHILDREN	H0019 HF HD TF	
☐	3.7	MEDICALLY SUPERVISED WITHDRAWAL MANAGEMENT	H0010 HF	
☐	3.7	MEDICALLY SUPERVISED WITHDRAWAL MANAGEMENT, ADOLESCENT	H0010 HF HA	

ELECTROCONVULSIVE THERAPY (ECT)
YES ☐ NO ☐

SECTION 4 – CLINICAL INFORMATION Complete all fields in their entirety for inpatient, SUD residential, or PRTF requests.	
REASON FOR ADMISSION:	**VOLUNTARY / INVOLUNTARY ADMISSION:** VOLUNTARY ☐ INVOLUNTARY ☐ NA ☐
IS THIS A READMISSION WITHIN THE LAST 30 DAYS? YES ☐ NO ☐ NA ☐	**IF YES, PLEASE EXPLAIN WHAT LED TO READMISSION**
IF APPLICABLE, DATES OF RECENT HOSPITALIZATIONS AND DISCHARGES	
MENTAL STATUS EXAM (E.G., APPEARANCE AND GENERAL BEHAVIOR, SPEECH, AND MOTOR ACTIVITY, AFFECT AND MOOD, THOUGHT AND PERCEPTION, ATTITUDE AND INSIGHT)	

SUICIDAL IDEATION YES ☐ NO ☐	**IF YES, PLEASE EXPLAIN**
HOMICIDAL IDEATION YES ☐ NO ☐	**IF YES, PLEASE EXPLAIN**
PSYCHOSIS YES ☐ NO ☐	**IF YES, PLEASE EXPLAIN**
APPETITE/SLEEP/HYGIENE (ADLS) IMPAIRED ☐ NO IMPAIRMENT ☐	**IF YES, PLEASE EXPLAIN**
MEDICAL CONDITIONS	
HISTORY OF TRAUMA YES ☐ NO ☐	**IF YES, PLEASE EXPLAIN**
FAMILY HISTORY OF MENTAL ILLNESS / SUD	**SUPPORTS** (PRIMARY AND COMMUNITY)
CURRENT LIVING SITUATION	**EMPLOYED / UNEMPLOYED / STUDENT**
LEGAL ISSUES (RECENT LEGAL HISTORY OR COURT INVOLVEMENT WITHIN THE LAST 6 MONTHS)	

CURRENT MEDICATIONS			
MEDICATIONS	**DOSAGE**	**RECENT CHANGE? (Y/N)**	**ADHERENCE**

TREATMENT AND SERVICE HISTORY			
Please list all known current and past behavioral health services. These may be outpatient, in-home, inpatient, and residential (including QRTP).			
SERVICE	**DATES** (START/END)	**PROVIDER**	**OUTCOME / RESPONSE**
DISCHARGE PLAN AND ANTICIPATED DISCHARGE NEEDS:			
OPTIONAL SPACE FOR ADDITIONAL DOCUMENTATION:			

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

Section 5 - SUD RESIDENTIAL	
Complete the additional fields below for SUD Residential requests	
CURRENT WITHDRAWAL SYMPTOMS YES ☐ NO ☐	**IF YES, PLEASE DESCRIBE**
HISTORY OF SEVERE WITHDRAWAL YES ☐ NO ☐	**IF YES, PLEASE DESCRIBE**
VITAL SIGNS:	
SUBSTANCE USE HISTORY/CURRENT USAGE PATTERN:	
URINE DRUG SCREEN (UDS)/BLOOD ALCOHOL LEVEL (BAL):	

SECTION 6 - PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

Complete the additional fields below for PRTF requests

REASON RESIDENTIAL TREATMENT IS REQUESTED AT THIS TIME: (CHECK ALL THAT APPLY)

- ☐ SELF-HARMING BEHAVIORS
- ☐ SUBSTANCE USE
- ☐ PHYSICAL AGGRESSION
- ☐ PROBLEMATIC SEXUAL BEHAVIORS
- ☐ PROBLEM EATING BEHAVIORS
- ☐ SUICIDAL BEHAVIORS
- ☐ OTHER: *PLEASE DESCRIBE*: _____

DESCRIBE THE MEMBER'S PROBLEMATIC BEHAVIORS WITHIN THE LAST 90 DAYS FOR EACH ITEM CHECKED ABOVE. INCLUDE SPECIFIC EXAMPLES WITH DETAILED INFORMATION ON SYMPTOMS, DURATION, FREQUENCY, INTENSITY, IMPACT, AND COMPLICATING FACTORS.

PLEASE DESCRIBE ANY HISTORY OF RUNNING AWAY FROM HOME OR OTHER LIVING ARRANGEMENTS. DETAIL ANY ELOPEMENT OR ATTEMPTS TO ELOPE FROM PREVIOUS TREATMENT SETTING INCLUDING RESIDENTIAL FACILITIES.

GRADE:	**EMPLOYMENT HISTORY:**
DOES MEMBER HAVE AN IEP OR 504? YES ☐ NO ☐	**IF YES, PLEASE EXPLAIN**

EXPLAIN ANY KNOWN/SUSPECTED COGNITIVE, FUNCTIONING, OR PROCESSING DEFICITS:

POSSIBLE BARRIERS TO TREATMENT:

SECTION 7 – ATTESTATION Complete all fields in their entirety.	
Printed Name of Provider/Clinician:	**Date (MMDDYYYY):**
Signature of Provider/Clinician:	

To prevent delay in processing your request for services, please attach clinical documentation / medical records to support your request. Please include the following: conservative treatment tried without success, applicable diagnostic testing with results, lab values and a medication list. Incomplete requests will delay the prior authorization process.

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