Member's Full Name: Medicaid #:

SERVICE AUTHORIZATION FORM

CMHRS & Behavior Therapy Services CONTINUED STAY Service Authorization Request Form

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Servicing Licensed Professional NPI # (For EPSDT Beh. Therapy only):	
Gender:	☐ Male ☐ Female ☐ Other	Provider Phone:	
Member Plan ID #:		Provider E-Mail:	
Member Address:		Provider Address:	
City, State, ZIP:		City, State, ZIP:	
Parent/Guardian:		Provider Fax:	
Parent/Guardian Contact Information:		Clinical Contact Name & Credentials*:	
Service Requested:	☐ Crisis Stabilization (H2019- Cont. Stay Only) ☐ Crisis Intervention (H0036- Cont. Stay Only) ☐ PSR (H2017) ☐ MHSS (H0046) ☐ Day Tx/PHP — Adult (H0035 HB) ☐ IIH (H2012) ☐ TDT — Child (H0035 HA) ☐ EPSDT Beh. Therapy (H2033) ☐ MH Peer [Individual] (H0025- Cont. Stay Only) ☐ MH Peer [Group] (H0024- Cont. Stay Only)	Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

If requesting TDT services, check one of the following: ☐ H0035 – HA (school day) ☐ H0035 – HA, UG (after-school) ☐ H0035 – HA, U7 (summer)
Provide the name of the school and/or setting where these services are being provided:
Initial Admission Date to Services:
Average # of units provided per week:
Request for approval of services: From _____ (date), To _____ (date), for a total of _____ units of service. Plan to provide _____ hours of service per week.

Primary ICD-10 Diagnosis	
Secondary Diagnosis	

Name of Medication	Dosage	Frequency
If additional medications are prescribed, include listing of medications, dosage, and frequency in the Notes section.		

Member's Full Name: Medicaid #:

SECTION I: CARE COORDINATION		
Please indicate other current medical/behavioral services and additional community interventions/supports received:		
Name of service/treatment	Provider/Contact Information	Frequency
Describe Care Coordination activities with other services and providers since the last authorization:		

SECTION II: TREATMENT PROGRESS
Treatment Goals/Progress: • Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. These should be written in the words of the individual or in a manner that is understood by the individual seeking treatment, include their individual strengths/barriers to/and gaps in service. If individual has identified a history of trauma, please include trauma-informed care interventions in the treatment plan. • Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential. • Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress. Include any appointments and medication adherence issues and plan to address this if applicable.
Resources and Strengths: Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports.
Please describe any barriers to treatment:
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific training and interventions will be provided to address this goal?

How will you measure progress on the interventions provided?
Progress toward Goal/Objective:
Lack of Progress and Changes made to ISP to address this:
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific training and interventions will be provided to address this goal?
How will you measure progress on the interventions provided?
Progress toward Goal/Objective:
Lack of Progress and Changes made to ISP to address this:
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):

How many days per week will be spent addressing this goal on average?
What specific training and interventions will be provided to address this goal?
How will you measure progress on the interventions provided?
Progress toward Goal/Objective:
Lack of Progress and Changes made to ISP to address this:
For IIH, TDT, and EPSDT BEHAVIOR THERAPY **Overview of family involvement during service period with regards to the individual's ISP to include who has been involved and progress made/continuing needs of family goals/training:**
For MHSS members under 21 years of age **If member is not currently living in an independent living situation and has been actively transitioning into independent living at the initiation of services, please describe progress toward this transition within 6 months of receiving services:**

Member's Full Name: Medicaid #:

SECTION III: DISCHARGE PLANNING		
DISCHARGE PLAN (Identify lower levels of care, natural supports, warm-hand off, care coordination needs)		
Step Down Service/Supports	Identified Provider/Supports	Plan to assist in transition
Estimated Date of Discharge:		
Recommended level of care at discharge:		

The Service Specific Provider Intake has been completed by an LMHP Type (and/or LBA for Behavior Therapy) and the individual's psychiatric history information reviewed. By my signature (below) I am attesting that the individual meets the medical necessity criteria for the identified service.

Signature (actual or electronic) of LMHP Type/LBA:_____

Printed Name of LMHP Type/LBA:_____

Credentials and NPI: _____
(NPI needed for Behavior Therapy only)

Date:_____

Member's Full Name: Medicaid #:

NOTES SECTION
If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.

Member's Full Name: Medicaid #:

PLEASE SEND FORM TO THE DESIGNATED HEALTH CARE PLAN USING THE CONTACT INFORMATION BELOW FOLLOWING THE TIME FRAME REQUIREMENTS ALSO BELOW

All MCOs rely on Contract Standards; 3 business days or up to 5 business days if additional information is required.

CONTACT INFORMATION			
Commonwealth Coordinated Care (CCC) Plus	Phone Number	Fax Number	Web Portal
Aetna Better Health of Virginia	855-652-8249	866-669-2454	https://www.aetnabetterhealth.com/virginia/providers/portal
Anthem HealthKeepers Plus	800-901-0020	866-877-5229	https://mediproviders.anthem.com/va/pages/precert.aspx
Magellan Complete Care of Virginia	800-424-4524	866-210-1523	Pending/TBA 2018
Optima Health Community Care	888-946-1168	844-348-3719 (BH Inpatient) 844-895-3231 (BH Outpatient)	www.optimahealth.com
United Healthcare	877-843-4366	855-368-1542	www.providerexpress.com
Virginia Premier Health Plan	844-513-4951	888-237-3997	Pending/TBA 4/1/2018

Community Mental Health Rehabilitation Services	Procedure Code	Registration vs. Authorization INTIAL REQUEST	Registration vs. Authorization CONTINUED STAY REQUEST
Mental Health Case Management	H0023	R	R
Mental Health Peer Support Services – Individual	H0025	R	A
Mental Health Peer Support Services – Group	H0024	R	A
Crisis Intervention	H0036	R	A
Crisis Stabilization	H2019	R	A
Intensive Community Treatment	H0039	A	R
Intensive In-Home	H2012	A	A
Therapeutic Day Treatment (TDT) for Children *TDT School Day	H0035 *HA	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Afterschool	H0035 *HA *UG	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Summer	H0035 *HA *U7	A	A
Day Treatment/ Partial Hospitalization *Adults	H0035 *HB	A	A
Mental Health Skill-building Services (MHSS)	H0046	A	A
Psychosocial Rehab	H2017	A	A
EPSDT Behavioral Therapy (ABA)	H2033	A	A

Timeframe Requirements for Submission (Concurrent)	CMHRS Services (excluding CI/CS)	CI/CS
Aetna	7 business days	48 hrs.
Anthem	14 business days	48 hrs.
MCC	7 business days	48 hrs.
Optima	7 business days	48 hrs.
United Healthcare	14 business days	48 hrs.
Virginia Premier	14 business days	48 hrs.