

Member's Full Name:

Medicaid #:



# SERVICE AUTHORIZATION FORM

## EPSDT Behavior Therapy INITIAL 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:		Provider Phone:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Parent/Guardian:		Clinical Contact Name & Credentials*:	
Parent/Guardian Contact Information:		Clinical Contact Phone:	
		* This is the individual to whom the MCO can reach out to answer additional clinical questions.	

<b>Admission Date:</b>	
<b>Request for Approval of Services:</b>	
From _____ (date), To _____ (date), for a total of _____ units of service. Plan to provide _____ hours of service per week.	
<b>Retro Review Request?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Is this a new service for the member?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, then complete an authorization for continuing care.)	
<b>Primary ICD-10 Diagnosis</b>	
<b>Secondary Diagnosis</b>	
Number of weekly hours requested for clinical supervision:	
Name and NPI of clinical supervisor: _____ ,	
Number of weekly hours for Service Coordination:	
Name and NPI of Services Coordinator (if applicable): _____ ,	
Number of weekly hours of direct service by unlicensed staff:	
Name and NPI of licensed staff delegating authority to the unlicensed staff: _____ ,	
Number of weekly hours of direct service by Licensed Staff:	
Name and NPI of licensed staff: _____ ,	

Member's Full Name:

Medicaid #:

<b>Referral source</b> – Must be a physician, nurse practitioner or physician assistant who is the child's primary care provider <u>or</u> another physician, nurse practitioner, or physician assistant provider familiar with the developmental history and current status of the child.					
Name	Profession	Address	Phone	Diagnosis (ICD-10)	Email Address
	<input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant				

Name of Medication	Dosage	Frequency

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

<b>SECTION I: EPSDT BEHAVIOR THERAPY TREATMENT ELIGIBILITY CRITERIA</b>	
<b>The individual has a level of impairment which requires treatment that cannot be provided by another DMAS program or a lower level of care/service and requires behavioral interventions and the expertise of a LMHP or a LBA or LABA. CMHRS services are not allowed concurrently with behavior therapy.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual must have a current psychiatric diagnosis as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) that is relevant to the need for behavioral therapy or have a provisional psychiatric diagnosis as developed by an LMHP when no definitive diagnosis has been made;</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is the member and their family willing to participate in services?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
What, if any, are the barriers to participation?	
<b>Individual must meet <u>TWO</u> of the following:</b>	
<b>Non-verbal or limited functional communication and pragmatic language, unintelligible or echolalic speech, impairment in receptive and/or expressive language</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the evidence for, and effects of this issue on the member's life:	
What other interventions have been tried/considered?	
Why were they ruled out?	
<b>Severe impairment in social interaction/social reasoning/social reciprocity/ and interpersonal relatedness</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the evidence for, and effects of this issue on the member's life:	

Member's Full Name:

Medicaid #:

What other interventions have been tried/considered?	
Why were they ruled out?	
<b>Frequent intense behavioral outbursts that are self-injurious or aggressive towards others</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the evidence for, and effects of this issue on the member's life:	
What other interventions have been tried/considered?	
Why were they ruled out?	
<b>Disruptive obsessive, repetitive, or ritualized behaviors.</b>	
Describe the evidence for, and effects of this issue on the member's life:	
What other interventions have been tried/considered?	
Why were they ruled out?	
<b>Difficulty with sensory integration</b>	
Describe the evidence for, and effects of this issue on the member's life:	
What other interventions have been tried/considered?	
Why were they ruled out?	

Member's Full Name:

Medicaid #:

<b>SECTION II: CARE COORDINATION</b>	
<b>Primary Care Physician:</b>	
<b>Are there medical health concerns that could affect the behavioral health issues? If yes, explain:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Plan to coordinate with primary care physician to help ensure medical concerns are addressed in relation to behavioral health treatment:</b>	

<b>SECTION III: TRAUMA-INFORMED CARE</b>	
<b>Trauma-Informed Care</b> (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)	
<b>Is there evidence to suggest this member has experienced trauma?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>What is your plan to assess/refer and address the current and potential effects of that trauma?</b>	

<b>SECTION IV: INDIVIDUAL TREATMENT GOALS</b>	
<b>SERVICE REQUIREMENTS</b>	
<b>Preliminary Treatment Plan: (must address the areas listed below delineated in the EPSDT Behavioral Therapy Program provider manual preliminary treatment plan Section as well as any identified barriers to participation)</b>	
Child-focused Behavior change goals:	
How many hours per week will be focused on the child behavior change goals?	
<b>Breakdown of total weekly hours requested</b>	
Number of hours for direct therapy time:	
Number of hours for clinical supervision:	
Number of hours for service coordination:	
Other (list type of activity and hours):	
Parent and caregiver goals:	
How many hours each week will at least one family member be committed to participate in treatment:	
Service Coordination goals:	

Member's Full Name:

Medicaid #:

<b>SECTION V: DISCHARGE PLANNING</b>		
<b>DISCHARGE PLAN</b> (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
Recommended level of care at discharge:		

Estimated Date of Discharge:

*The Service Specific Provider Intake has been completed by an LBA/LMHP Type 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 & NPI:

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
<b>Aetna Better Health of Virginia</b>	855-652-8249	866-669-2454	<a href="https://www.aetnabetterhealth.com/virginia/providers/portal">https://www.aetnabetterhealth.com/virginia/providers/portal</a>
<b>Anthem HealthKeepers Plus</b>	800-901-0020	866-877-5229	<a href="https://medproviders.anthem.com/va/pages/precert.aspx">https://medproviders.anthem.com/va/pages/precert.aspx</a>
<b>Magellan Complete Care of Virginia</b>	800-424-4524	866-210-1523	Pending/TBA 2018
<b>Optima Health Community Care</b>	888-946-1168	844-348-3719 (BH Inpatient) 844-895-3231 (BH Outpatient)	<a href="http://www.optimahealth.com">www.optimahealth.com</a>
<b>United Healthcare</b>	877-843-4366	855-368-1542	<a href="http://www.providerexpress.com">www.providerexpress.com</a>
<b>Virginia Premier Health Plan</b>	844-513-4951	888-237-3997	Pending/TBA 4/1/2018

Community Mental Health Rehabilitation Services	Procedure Code	Registration vs. Authorization INITIAL 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.