**Please note Section I of this form is required for ALL requests.**

**Please check which of the following services you are requesting authorization:**

[ ]  **Assessment** *Complete Section I*

[ ]  **Request for prior approval of treatment services** C*omplete Section I for all chemical health*

[ ]  **Notification of treatment start** *Complete Section I. \*If assessment is more than 45 days old, complete section II as well\**

[ ]  **Ongoing or concurrent treatment services** *Complete Sections I and II. Note: you may submit your own current treatment plan instead of section II.*

[ ]  **Retrospective services only** *Complete Section I and also include progress notes and a discharge summary with your request.*

 **SECTION I: MUST BE FILLED OUT COMPLETELY FOR ALL REQUESTS**

|  |  |
| --- | --- |
| **Member Name:****FDSAF** | **Member DOB:****12/6/2016** |
| **BHP Authorization # (if applicable):** | **Insurance Member ID:** |
| **Date request is being submitted:** |  |

|  |  |
| --- | --- |
| **Facility Name:** | **Address:** |
| **NPI# for Treatment:**  | **NPI# for Room/Board (if applicable):** |
| **Facility Contact Phone #:** | **Facility Contact Fax #:** |
| **Facility Contact Name:**  | **Counselor Name & Signature:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date Span Requested for this authorization** | **Treatment Setting / Type** | **Services Requested for this authorization** | **Complexity** **(if applicable)** | **MAT information** **(if applicable)** |
| **Start Date:**      **End Date:**      Primary Chemical Health Diagnosis:      Initial Treatment Start Date (If different from authorization start date. Regardless of funding source):       | [ ]  Hospital-Based Residential [ ]  Residential (treatment plus room and board)[ ]  Outpatient[ ]  Room and Board (separate from treatment)[ ]  CD Assessment  [ ]  H0001[ ]  Medication Assisted Therapy (MAT) [ ]  Service Coordination | **OUTPATIENT** Total group hours:       (H2035HQ)Frequency of visits:      Total individual hours:       (H2035)**RESIDENTIAL**Number of **Residential** days requested:      | [ ]  Adolescent HA[ ]  Co ‐ Occurring HH[ ]  Special Populations U4[ ]  Client w/Child U6[ ]  Medical Services U5[ ]  Residential High Intensity TG[ ]  Residential Medium Intensity TF[ ]  Residential Low Intensity UD |  **Medication Assisted Therapy (MAT)** [ ]  H0020 or[ ]  H0047Total Units:     MethadoneComplexity: (if applicable)[ ]  U8 [ ]  U9[ ]  UA[ ]  UB |

 **SECTION II: MUST BE FILLED OUT COMPLETELY FOR ALL REQUESTS**

*Please complete this section to request ongoing/concurrent treatment services or to updated an outdated assessment.*

|  |  |
| --- | --- |
| ***Dimension 1: Acute Intoxication/Withdrawal Potential*** | **[ ] 0** **[ ] 1** **[ ] 2** **[ ] 3** **[ ] 4**  |
| **Date of Last Use of chemicals:** |
| **Reason risk rating assigned:** |
| ***Dimension 2: Biomedical Complications and Conditions*** | **[ ] 0** **[ ] 1** **[ ] 2** **[ ] 3** **[ ] 4**  |
| **Medical conditions that are a barrier to treatment:** | **Are medical conditions being addressed by other providers? Yes** **[ ]  No** **[ ]**  |
| **Reason risk rating assigned:** |
| ***Dimension 3: Emotional, Behavioral, Cognitive Conditions and Complications: \*Note: For a risk rating of 2 or greater, DHS guidelines require referral to a mental health provider.***  | **[ ] 0** **[ ] 1** **[ ] 2** **[ ] 3** **[ ] 4** **Mental Health Diagnosis:**  |
| **Mental Health Services Being Received:****[ ] Psychiatry [ ] Therapy [ ] Other (please describe)**  | **Current Psychotropic Medications:** |
| **How is your program coordinating care with the mental health provider(s)?****[ ] Verbally [ ] In Person/On site [ ] Written/Faxed [ ] Not coordinating (and why)** |
| **Reason risk rating assigned:** |
| ***Dimension 4: Readiness for Change*** | **[ ] 0** **[ ] 1** **[ ] 2** **[ ] 3** **[ ] 4**  |
| **Reason risk rating assigned:** |
| ***Dimension 5: Relapse, Continued Use, and Continued Problem Potential*** | **[ ] 0** **[ ] 1** **[ ] 2** **[ ] 3** **[ ] 4**  |
| **Has the client relapsed in treatment?** **[ ] Yes** **[ ] No** **If yes, what interventions have been implemented to address the relapse?**  |
| **Reason risk rating assigned:** |
| ***Dimension 6: Recovery Environment*** | **[ ] 0** **[ ] 1** **[ ] 2** **[ ] 3** **[ ] 4** |
| **Is family involved in care? Yes** **[ ]  No** **[ ]** **If YES, how is family involved?****If NO, why not?** |
| **Clinical criteria & goals to be met for program completion:** |
| **Date of expected discharge:** | **Current continuing care plan & location:**  |
| **Reason risk rating assigned:** |