**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:** | **Member DOB:** |
| **BHP Certification # (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  H0047  Total Units:    Methadone  Complexity:  (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:** | | |