Community HEALTH OPTIONS®

Behavioral Health Notification/ Prior Approval Form

Fax completed form to Medical Management to (877) 314-5693

Updated: 11/1/2019

Member Information (*Denotes Required Field)		
*Patient Name:	*☐ Male *☐ Female	*DOB:
*Health Insurance ID#:	Other Health Insurance (please specify):	
Address:	Phone:	

☐ **Routine** ▸ Routine Pre-Service requests will generally be processed within 72 hours or two business days, whichever is earliest, upon receipt of all medically necessary information.

☐ **Urgent** ▸ Urgent Pre-Service requests will generally be processed within one calendar day of receipt of all necessary information. Urgent requests are based on clinical presentations that could seriously jeopardize the Member's life or health, ability to regain maximum function, or subjects the Member to severe pain that cannot be adequately managed without the requested care or treatment. To initiate urgent referrals by phone 24/7 call (855) 542-0880.

Emergency services (911 ambulance transport and ED evaluation/treatment) do not require Prior Approval.

Provider Information	
***Requesting/Ordering Provider:**	***Servicing/Rendering Provider or Facility:**
*Name:	*Name:
*Address:	*Address:
*Tel:	*Tel:
*Fax:	*Fax:
*Contact Person:	*Specialty:
*Contact Tel:	*NPI:
*NPI	Please list additional provider information, if applicable, to include name, NPI & location.
Clinical Summary or clinical notes must be attached. Incomplete information may delay decision process.	

Requested Service(s) Requiring Prior Approval (Check All That Apply) NOTE: HMO coverage is limited to in-network services.

Outpatient Services (Must submit PA form & clinical within 10 BD of date of service):

- ☐ Applied Behavioral Analysis (ABA)
- ☐ Assertive Community Treatment (ACT)
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Intensive Outpatient Services (IOP)
- ☐ Psychological and Neuropsychological Testing
- ☐ Transcranial Magnetic Stimulation (TMS)
- ☐ Out of Network individual/group therapy at the 9th visit and beyond
- ☐ Out of network medication management at the 9th visit and beyond
- ☐ Urine Drug Screening (please complete UDS section on pg. 2)

Requires Notification (within 10 BD of date of service):

- ☐ Crisis Evaluation

Note: Clinical review for medical necessity is waived, but notification within 10 BD is required to avoid claim denial for lack of notification. Notification triggers care management support.

Hospital, Observation and Admissions (notification with clinical information is required within 48 hours unless otherwise specified):

- ☐ Acute Inpatient Psychiatric Admission
- ☐ Medical Detoxification Admission
- ☐ Observation (note: Observation is limited to 48 hours: admit or discharge to lower level of care)
- ☐ Partial Hospitalization Program (PHP)
- ☐ Residential Detoxification and/or Rehabilitation
- ☐ Crisis Stabilization Unit

continued

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Diagnosis Information (*Denotes Required Field) Note: Please list all applicable diagnoses."	
*ICD10 (List codes AND description):	
1.	4.
2.	5.
3.	6.

Planned Procedure Information (*Denotes Required Field)

☐ **Transportation (Air/Ground/Water)**
Transport coverage is limited to the nearest medical facility licensed and capable of providing the medically necessary level of care.

☐ **Out-of-network (OON) services**
For all OON Services, please advise Member to call Member Services at (855) 624-6463 to inquire about OON benefit coverage.

Urine Drug Screening:

☐ **UDS benefit limit (per rolling 12 months):**
- 20 Presumptive (qualitative)
- 20 Definitive (quantitative)

☐ **Urine Drug Screening (presumptive; qualitative)**

☐ **Urine Drug Screening (definitive; quantitative)**

Note: Community Health Options does not cover urine drug testing in any of the following circumstances:

- Testing ordered by third parties, such as school, courts, or employers or requested by a provider for the sole purpose of meeting the requirements of a third party.
- Testing for residential monitoring.
- Routine urinalysis for confirmation of specimen integrity.

CPT/HCPCS Code*	Brief Description of Service	# of units or visits	CPT/HCPCS Code*	Brief Description of Service	# of units or visits
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

*Date(s) of service/ planned procedure/admission:

Start: End:

Fax completed form with clinical notes to Medical Management (877) 314-5693. If submitting via Provider Portal, please upload this document with clinical notes.