COMMUNITY Health Options™

Behavioral Health Notification/ Prior Approval Form

Submit authorization requests via: Provider Portal (preferred): Provider.HealthOptions.org
Health Options (Medical Management): Fax: (877) 314-5693 Phone: (855) 542-0880

Updated: 1/1/2021

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
- ☐ Assertive Community Treatment (ACT)
- ☐ Crisis Evaluation (notification only if within 10 BD
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Intensive Outpatient Services (IOP)
- ☐ Partial Hospitalization Program (PHP)
- ☐ Transcranial Magnetic Stimulation (TMS)

☐ Urine Drug Testing (UDT) - Prior Approval is required if performed by an out-of-network lab/provider.

- ☐ Presumptive (qualitative or QL) - specify # _____
- ☐ Definitive (quantitative or QT) - specify # _____

Note: UDT benefit limit per calendar year: 20 QL and 20 QT

UDT limit applies to all in-network and out-of- network services.

UDT Exclusions: UDT ordered by a third party (e.g., school, court, employer), residential monitoring, or routine urinalysis for confirmation of specimen integrity)

Psychological & Neuropsychological Evaluation	Initial (check all that apply)	Additional (specify # of hours or minutes)
Psychological Test Evaluation	☐ First Hour	Each additional hour specify # _____
Neuropsychological Test Evaluation	☐ First Hour	Each additional hour specify # _____
Psychological Test Administration/ Scoring	☐ First 30 minutes	Each additional 30 min specify # _____
Neuropsychological Test Administration/ Scoring	☐ First 30 minutes	Each additional 30 min specify # _____

continued

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Hospitalization, Observation, Admissions: Require medical necessity of the entire stay. Notification with submission of written clinical information is required within 48 hours unless otherwise specified.

- ☐ Observation (limited to 48 hours – admit or transfer to a lower levelof care)
- ☐ Acute Inpatient Psychiatric Admission
- ☐ Inpatient Medical Withdrawal Management
- ☐ Crisis Stabilization Unit
- ☐ Residential Treatment

Diagnosis Information (*(Please list all appliable diagnoses and brief descriptions- required fields)	
*ICD10 (List codes AND description):	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

For all out-of-networkservices,please advise Member to call Member Services at [855] 624-6463 to inquire about benefit coverage.

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:

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