Wellpoint

Behavioral Health Outpatient Treatment Prior Authorization Request Form

Fax to 844-442-8010

Availity Essentials, our preferred digital method, at **Availity.com**, can be used to request prior authorizations and to find information on a request previously submitted via phone, fax, or online.

Fill out completely to avoid delays.

Patient information:		
Patient's name:	Member ID:	
Medicaid/CHIP ID:	Date of birth:	
Patient's address:		
City:	State:	Zip:
Provider information: individual and/or group		
Name:		
Provider's NPI:	Provider's TIN:	
Phone:	Fax:	
Address:		
City:	State:	ZIP:
ICD-10 diagnosis codes		

Current authorizations being requested:

Requested service authorization		
Procedure code:	Number of units:	
Frequency:	Requested start date:	End date:
Estimated number of units required to complete treatment:		
Rendering provider if different than requesting (including TIN and NPI):		
Requested service authorization		
Procedure code:	Number of units:	
Frequency:	Requested start date:	End date:
Estimated number of units required to complete treatment:		
Rendering provider if different than requesting (including TIN and NPI):		

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Medications		
Current medications (indicate changes since last report)	**Dosage**	**Frequency**

Current risk factors

Suicide:	☐ None ☐ Ideation ☐ Intent without means ☐ Intent with means ☐ Contracted not to harm self
Homicide:	☐ None ☐ Ideation ☐ Intent without means ☐ Intent with means ☐ Contracted not to harm others
Hallucinations:	☐ Audio ☐ Visual ☐ Both ☐ Neither
Physical or sexual abuse or child/elder abuse:	☐ Yes ☐ No
If yes, patient is:	☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse exists in family
Abuse or neglect involves a child or elder:	☐ Yes ☐ No
Abuse has been legally reported:	☐ Yes ☐ No

Please complete all boxes that are applicable for this patient or attach additional clinical information:

Symptoms that are the focus of current treatment

Progress since last review
Functional impairments/strengths (including interpersonal relations, personal hygiene, work/school)
Recovery environment (describe, including support system, level of stress)
Engagement/level of active participation in treatment
Housing
Co-occurring medical/physical illness
Family history of mental illness or substance use

For substance use disorders, please complete the following additional information:

Current assessment of American Society of Addiction Medicine (ASAM) criteria	
Dimension (describe or give symptoms)	**Risk rating**
Dimension 1 (acute intoxication and/or withdrawal potential; include vitals, withdrawal symptoms):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension 2 (biomedical conditions and complications):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension 3 (emotional, behavioral, or cognitive complications):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension 4 (readiness to change):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension 5 (relapse, continued use or continued problem potential):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
Dimension 6 (recovery living environment):	☐ Minimal/none ☐ Mild ☐ Moderate ☐ Significant ☐ Severe
If any ASAM dimensions have moderate or higher risk ratings, how are they being addressed in treatment or discharge planning?	

Patient's treatment history, including all levels of care

Level of care	Number of distinct episodes or sessions	Date of last episode or session
Outpatient psych		
Inpatient psych		
Outpatient substance use		
Inpatient substance use		
Psychiatric Medical Institute for Children		
Chemical dependency residential treatment program		
Other:		

Treatment goals for each type of service (specify) with expected dates to achieve them
1.
2.
3.
4.
5.
Objective outcome criteria by which goal achievement is measured
1.
2.
3.
4.
5.
Discharge plan and estimated discharge date

Expected outcome and prognosis:

☐ Return to normal functioning

☐ Expect improvement, anticipate less than normal functioning

☐ Relieve acute symptoms, return to baseline functioning

☐ Maintain current status, prevent deterioration

Please attach summary sheets of any applicable assessments.

Psychological/neuropsychological testing requests require a separate form.

Treatment plan coordination	
I have requested permission from the member/member's parent or guardian to release information to the PCP/psychiatrist.	☐ Yes ☐ No
If no, rationale why this is inappropriate:	
Treatment plan was discussed with and agreed upon by the member/member's parent or guardian.	☐ Yes ☐ No

Provider signature:
Date: