Wellpoint

Behavioral health honor authorization request

This form is to request prior authorization for members whose benefits are currently suspended due to placement at a state hospital facility or incarceration. Honor authorizations must be faxed to **844-430-6806**. Honor authorization cannot be requested via phone or Availity.

To avoid delays in processing, please **do not** write *see attached*.

Date:			
Member information			
Name:			
ID number:		DOB:	
Address:			
Phone number:			
Provider information			
Admitting facility name:			
Admitting facility phone:			
Admitting facility fax:			
Date of admission:		NPI:	
Admitting status:	☐ Voluntary ☐ Involuntary ☐ Parent-initiated treatment		
Current status:	☐ WSH ☐ESH ☐ Incarceration facility		
Length of stay:			
Admitting UMR contact name:			
Requestor phone:		Requestor fax:	
Requested level of care:			
If ASAM, provide specific level of care:			
**** The prescriber admission note must accompany this request, if applicable. ****			
Behavioral health and physical health diagnoses:			
Precipitant to admission: What specific events lead to admission? Why is the treatment needed now? Include reasons why admission is medically necessary and include any precipitating legal events.			

Substance use or dependence: ASAM dimensions, current UA/lab results and pattern of use (substances, last use, frequency, duration, sober history, vitals). Please include CIWA, COWS scores (if applicable) along with the dates they were taken. Please include clinical picture if member was not in current facility.
Current treatment plan
Standing medications for behavioral and physical health (include name of medication, mg strength and frequency for each):
As-needed medications that have been administered [indicate name of medication, mg strength and frequency for each. Indicate the reason(s)/trigger(s), date(s)/time(s)]:
Other treatment and/or psychosocial interventions planned:
Date of recent and upcoming family therapy sessions:
Support system (Include coordination activities with case managers, family, community agencies, etc. If the case is open with another agency, list the agency name, phone number and case number.):
Initial discharge plan List name and number of discharge planner and include whether the member can return to current residence. If homeless, document the plan for housing. Document any current barriers to discharge.

Number of days requested:		Estimated discharge date:	
Submitted by (print name):			
Signature:			