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Mental health treatment authorization request/notification

Please complete all fields below as indicated, select the appropriate level of care and attach relevant clinical documentation. **Fax the completed form and clinicals to 503-416-4727.**

Date of request: _____

Date of service requested/admission (can be estimated or TBD. Please do not write ASAP.)

Date:_____

☐ Expedite request (standard timeline for review would seriously jeopardize the health and safety of the member). Please do not select this box if placement or admission availability is greater than 14 days.

Member information

Member name:_____ Member OHP ID#: _____

DOB: _____

Requesting provider information

Requesting provider name: _____

Clinic name, if relevant: _____

Provider contact person: _____

Provider contact person email: _____

Contact phone#: _____ Contact fax#: _____

Delivering provider information

Delivering provider or clinic, if known (if not known, enter "TBD Behavioral Health provider"): _____

Please note: this does not constitute a referral and services must be coordinated with provider once identified

Service Types we can process with provider TBD Behavioral Health Provider:

- Youth subacute
- Eating disorder partial hospitalization/IOP
- Youth PRTS
- Psychological testing
- Youth day treatment/Partial hospitalization
- Applied Behavioral Analysis (ABA)
- Transcranial magnetic stimulation (TMS) (uncommon)
- Eating disorder residential
- Electroconvulsive therapy (ECT) (uncommon)

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Authorization request/Notification type

Primary DSM 5 diagnosis and severity: _____

_____

◯ Initial authorization/notification request

OR

◯ Continued stay request (enter original authorization number): _____

OR

◯ Request for additional funding for non-expired existing authorization (enter original authorization number):

The following information must be submitted with your additional funds request. This may be entered below or included in supporting documentation:

* Number of additional sessions and codes:_____

* Clinical justification (DSM 5 diagnosis, member's condition, services needed, and/or reason for continued services)

_____

* Effectiveness of current interventions on members care plan objectives:

_____

* If no improvement or treatment has not been effective, what will be done differently and what is expected to change/improve within the additional sessions?

_____

*Individualized plan that includes the elements below:

◯ The expected benefit and outcomes from continued services

◯ Specific and measurable goal(s) of services

◯ Expected duration of the services

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Please select only one level of care

Documentation required/ clinically reviewed	Documentation not required/ not clinically reviewed (notification only)
◯ Applied Behavioral Analysis ABA ◯ DBT Intensive Outpatient (IOP) ◯ Partial Hospital (PHP)/Intensive Outpatient (IOP) ◯ Subacute ◯ Psychiatric day treatment services (PDTS) ◯ Psychiatric residential treatment services (PRTS) ◯ Eating disorder residential ◯ Eating Disorder Partial Outpatient IOP ◯ Transcranial magnetic stimulation (TMS) *Specify code(s) and units:*_____ ◯ Electroconvulsive therapy (ECT) *Specify code(s) and units:* _____ ◯ Psychological testing *Specify code(s) and units:* _____ (N/A if provider is TBD or is different than the referring provider) **Note:** *Neuropsychological testing must be requested under the members physical health plan*	◯ **General Outpatient** (assessment and treatment) ◯ **Levels of Care** (only to be used by contracted servicing providers) **Levels of Care** (only to be used by contracted servicing providers) ◯ Assessment Plus Two ◯ Level A OP MH ◯ Level A Adult SPMI ◯ Level B OP MH ◯ Level B Adult SPMI ◯ Level C OP MH ◯ Level C Adult SPMI ◯ Level D TAY **Note:** *-Use the ACT/Adult Level D request form for ACT/ICM* *-Use the Level D Child referral form for Level D Child*