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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 503-416-3713**.

Date of request: ______________________

☐ Expedite request (standard timeline for review would seriously jeopardize the health and safety of the member)

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"): ____

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

Levels of service we can process with provider TBD:

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

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Authorization request/Notification type

Date of service requested/admission (can be estimated)

Date: ____________________

Primary DSM 5 diagnosis and severity: ____________________

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☐ 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: ____________________

* Explanation of the medical need for continued services: ____________________

* Clinical justification for the DSM 5 diagnosis that is a covered diagnosis on Oregon's prioritized list the member's condition and services that will be needed:

* 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)
☐ ABA assessment ☐ ABA treatment ☐ Intensive outpatient (IOP) ☐ Partial hospital (PHP) ☐ Subacute treatment youth ☐ Subacute treatment adult ☐ Psychiatric day treatment services (PDTS) ☐ Psychiatric residential treatment services (PRTS) ☐ Eating disorder residential ☐ Eating disorder partial hospitalization ☐ Eating disorder intensive outpatient ☐ Transcranial magnetic stimulation (TMS) *Specify code(s) and units:*____________________ ☐ Electroconvulsive therapy (ECT) *Specify code(s) and units:* ____________________ ☐ Anesthesia for ECT ☐ 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*	☐ Assessment FFS ☐ General outpatient FFS ☐ Medication management FFS ☐ DBT outpatient ☐ Behavioral health in primary care (BHiPC) **Outpatient adult** ☐ Level A adult ☐ Level B adult ☐ Level C adult ☐ Level D adult/TAY **Note:** *Use ACT/ICM request for form Adult Level D/ICM)* **Outpatient child** ☐ Level A child ☐ Level B child ☐ Level C child ☐ Community based intensive treatment (CBIT) ☐ Oregon intercept (Youth Villages) **Note:** *Use the Youth Level D referral form for Level D Child*