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: 1/1/2022

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 & written clinical within 10 business days (BD) of date of service):

- ☐ Applied Behavioral Analysis
- ☐ Assertive Community Treatment (ACT)
- ☐ Electroconvulsive Therapy (ECT)
- ☐ Intensive Outpatient Services (IOP)
- ☐ Partial Hospitalization Program (PHP)
- ☐ Transcranial Magnetic Stimulation (TMS)

Notification required:
Crisis Evaluation

☐ 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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Observation & Admissions require medical necessity review of the entire stay. Notification with submission of written clinical information is required within 48 hours (by 12 noon the first business day following a weekend or holiday admission).

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

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-network services, 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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