



Member Information

Plan: Medi-Cal Medicare DUALS Marketplace Date of Request: _____ Admit Date: _____

Request Type: Initial Concurrent

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone: _____

Service Is: Elective/Routine Expedited/Urgent*

*Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

Provider Information

Treatment Provider/Facility/Clinic Name and Address: _____

Provider NPI/Provider Tax ID# (number to be submitted with claim): _____

Attending Psychiatrist Name: _____

UR Contact Name: _____ UR Phone#/Fax#: _____

Facility Status: PAR Non-PAR Member Court Ordered? Yes No In Process Court Date: _____

Service Type Requested

Service is for: <input type="checkbox"/> Mental Health <input type="checkbox"/> Substance Use		
<input type="checkbox"/> Inpatient Psychiatric Hospitalization <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary	<input type="checkbox"/> Residential Treatment <input type="checkbox"/> Partial Hospitalization Program <input type="checkbox"/> Day Program	<input type="checkbox"/> Electroconvulsive Therapy (ECT) <input type="checkbox"/> Psychological/Neuropsychological Testing (*see page 3 for details) <input type="checkbox"/> Non Contracted Outpatient Services <input type="checkbox"/> Other - Describe: _____
<input type="checkbox"/> Subacute Detoxification <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary		
If Involuntary, Court Date: _____		

Procedure Code(s) and Description Requested: _____

Length of Stay Requested: _____

Dates of Service Requested: _____

Primary Diagnosis Code for Treatment (including Provisional Diagnosis)	
Additional Diagnoses (including any known Medical Diagnoses/Conditions)	
Psychosocial Barriers (formerly Axis IV)	

For Molina Use Only:

Clinical Review - Initial and Concurrent

Functioning: Presenting/Current Symptoms that Necessitate Treatment (or Continued Treatment)

* Denotes Documentation of Safety Plan Completed under Additional Information

- | | | |
|--|---|--|
| <input type="checkbox"/> *Suicidal ideations/plan/attempt
<input type="checkbox"/> *Homicidal ideations/plan/attempt
<input type="checkbox"/> *History of Suicidal/Homicidal actions
<input type="checkbox"/> Hallucinations/Delusions/Paranoia
<input type="checkbox"/> Self-Mutilation (ex. cutting/burning self)
<input type="checkbox"/> Mood Lability
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Appetite Changes
<input type="checkbox"/> Significant Weight Gain/Loss
<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> Poor Motivation
<input type="checkbox"/> Cognitive Deficits
<input type="checkbox"/> Somatic Complaints
<input type="checkbox"/> Anger Outbursts/Aggressiveness
<input type="checkbox"/> Inattention | <input type="checkbox"/> Impulsivity
<input type="checkbox"/> Legal Issues
<input type="checkbox"/> Problems with Performing ADLs
<input type="checkbox"/> Poor Treatment Compliance
<input type="checkbox"/> Social Support Problems
<input type="checkbox"/> Learning/School/Work Issues
<input type="checkbox"/> Substance Use Interfering with Functioning |
|--|---|--|

*Medication Administration Document can be submitted in lieu of completing the below

Medication Name	Dosage/ Frequency	New from Admit?	Date Current Dose Initiated	Compliant?	Lab/Plasma Level?
		<input type="checkbox"/> New		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> New		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> New		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> New		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> New		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional Information (explanation of any checked symptoms or other pertinent information):

*For Inpatient, RTC, and Partial Hospitalization/Day Treatment - Please submit current (within the last 48 hours) Medical Progress Notes for Clinical Review

*For ECT, Psychological/Neuropsych Testing and Non-Contracted OP Requests – see page 3 for additional information required for review

Aftercare Plan/Follow-up Appointment

Expected Discharge Date: _____

Follow-Up Appointment Scheduled: YES NO
(Complete if member is in Inpatient Hospitalization)

*NOTE: First follow-up apt must be scheduled within 7 (seven) days of discharge.

Provider Type	Provider Name	Telephone Number	Date of Appointment	Time of Appointment

Is treatment being coordinated with the Psychiatrist or Behavioral Health Practitioner? Yes No

If Yes, Name of Provider: _____ Last Contact Date with Provider: _____

If No, please explain: _____

NOTE: Level of Care coverage is subject to State Contract Specific Covered Services. Please refer to the State Specific Provider Handbook for a list of covered levels of care. Authorization of services does not guarantee payment. Payments for services are pending eligibility at the time of service and benefit coverage.

Clinical Information

Please provide the following information with the request for review:

Neuropsychological/Psychological Testing: *as covered per benefit package

- Diagnoses and neurological condition and/or cognitive impairment (suspected or demonstrated)
- Description of symptoms and impairment
- Member and Family psych /medical history
- Documentation that medications/substance use have been ruled out as contributing factor
- Test to be administered and # of hours requested, over how many visits and any past psych testing results
- What question will testing answer and what action will be taken/How will treatment plan be affected by results

Electroconvulsive Therapy (ECT):

Acute/Short-Term: *as covered per benefit package

- Acute symptoms that warrant ECT (specific symptoms of depression, acute mania, psychosis, etc.)
- ECT indications (acute symptoms refractory to medication or medication contraindication)
- Informed consent from patient/guardian (needed for both Acute and Continuation)
- Personal and family medical history (update needed for Continuation)
- Personal and family psychiatric history (update needed for Continuation)
- Medication review (update needed for Continuation)
- Review of systems and Baseline BP (update needed for Continuation)
- Evaluation by anesthesia provider (update needed for Continuation)
- Evaluation by ECT-privileged psychiatrist (update within last month needed for Continuation)
- Any additional workups completed due to potential medical complications

Continuation/Maintenance: *as covered per benefit package

- Information updates as indicated above
- Documentation of positive response to acute/short-term ECT
- Indications for continuation/maintenance

Non Contracted Outpatient Services

Initial:

- Rationale for utilizing Out of Network provider
- Known or Provisional Diagnosis

Concurrent/Ongoing:

- Rationale for utilizing Out of Network provider
- Personal and family psychiatric medical history (comprehensive assessment/History and Physical are acceptable)
- Medication review
- Known barriers to treatment and other psychosocial needs identified
- Treatment plan including ELOS and discharge plan
- Additional supports needed to implement discharge plan