



Instructions for Submitting Behavioral Health Prior Authorization Requests

Requests for Behavioral Health Prior Authorizations to the Utilization Management Department may be sent by telephone, fax, or mail based on the urgency of the requested service.

Phone numbers and address are:

Telephone: (800) 642-4168 Prompt 1, 1 **Mail:** Molina Healthcare of Ohio, Inc. *Attention: Behavioral Health*
Fax: (866) 553-9262 **P.O. Box 349020**
Columbus, OH 43234-9020

Providers are encouraged to use the Molina Healthcare of Ohio Prior Authorization Form. If using a different form, the Provider is required to supply the following information, as applicable, for the requested service:

<ul style="list-style-type: none"> • Member demographic information (name, DOB, social security #) • Provider information (Referring Physician and Referred to Specialist) • Requested service/procedure (including specific CPT/HCPCS Codes) • Member diagnosis (ICD-9 or DSM IV Code and description) 	<ul style="list-style-type: none"> • Clinical indications necessitating service or referral • Pertinent medical history (incl. treatment, diagnostic tests, examination data) • Requested number of visits and frequency of visits over what duration.
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Molina Healthcare of Ohio, Inc. will process any “non-urgent” requests as quickly as possible but no later than 14 days after receipt of a request. “Urgent” requests will be processed as soon as possible within 3 days of receipt of the request.

Upon approval the requestor will receive an authorization number. The number may be provided by phone or fax. **Please include this authorization number on your claim.** If a request must be denied, the requestor will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials are also communicated to the provider by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails. Verbal and fax denials are given within one business day of making the denial decision, or sooner if required by the member’s health condition. The written letter is mailed at the time the denial is issued.

RECONSIDERATIONS (FOR SUBMITTING ADDITIONAL CLINICAL DATA)

Providers may call Utilization Management at 1-800-642-4168 to request reconsideration of adverse determination or submit the reconsideration request in writing to: Molina Healthcare of Ohio, Inc, Attn: Utilization Management/Behavioral Health, PO Box 349020, Columbus, OH 43234-9020. Reconsiderations are available for services not yet provided. **It is Molina’s policy not to conduct retrospective authorizations**

APPEALS

Providers may appeal on behalf of a member. Details regarding the appeals process can be found in the Molina Provider Manual.

EXTENSIONS OF AUTHORIZATIONS

Once a referral has been previously *approved*, the specialist or vendor may call Molina Healthcare of Ohio, Inc. directly to request an extension of services and provide the information on this form except section 5, or complete All Sections of this form except section 5.

Services Requiring Prior Authorization	Services Not Requiring Prior Authorization
<ul style="list-style-type: none"> • Inpatient detoxification and therapeutic intervention for Chemical Dependency. • Outpatient Mental Health and Chemical Dependency Services (Note: An authorization number for the initial assessment and 4 subsequent visits will be issued.) • All outpatient services exceeding 5 visits require submission of an updated Care Plan prior to the 5th visit to avoid any delays in approved sessions. • Psychological or Neuropsychological Testing • ECT (electro-convulsive therapy) • Alternative levels of care • Services provided by a non-participating provider 	<ul style="list-style-type: none"> • Initial assessment (CPT Code 90801) by a participating Psychiatrist, APRN, or PCP • Medication management (CPT Code 90862) by participating provider • Psychiatrist services in a private or public free-standing Psychiatric Hospital are covered when billed independently of hospital. • Non-covered services (Please contact Utilization Management/Behavioral Health) for information on non-covered services such as, but not limited to, ambulatory detoxification and partial hospitalization.
	Limitations
	<ul style="list-style-type: none"> • Services provided by Community Mental Health Centers and ODADAS contracted facilities are not covered pursuant to ORC Section 5111.16. • Inpatient psychiatric care in a private or public free-standing Psychiatric Hospital.

Prior Authorization Guidelines

- Call Molina to obtain Authorization for the Assessment and the initial four visits prior to or at the time of the Assessment visit.
- Please **complete all fields on the form with ALL requests for authorization.**
- Submit this completed form prior to the 5th visit to avoid any delays in approved sessions. You must receive prior authorization approval for visits 6 or greater to obtain reimbursement. Prior authorization for services beyond the 5th visit must be obtained prior to the service being provided.



Service Request Form (for Behavioral Health Prior Authorization)

Phone number: 1-800-642-4168 Fax: 1-866-553-9262

Section 1 Member Information

Member Name: (Last, First, MI)		Date of Birth: / /	Member I.D:
Address: (No., Street, City, State, Zip)			Phone Number: ()
Service is: <input type="checkbox"/> Initial Request or <input type="checkbox"/> Updated Request <input type="checkbox"/> Medically Emergent (Needed within 72 hours)		Is there another Insurance Carrier for this service? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, Name of Company _____	

Section 2 Provider Information

Provider rendering services (Include Degree):		Phone Number: ()	Fax Number: ()
Agency:	Address: (No., Street, City, State, Zip)		
Provider/Supervising Signature (Include Degree): _____			

Section 3 Care Coordination Contacts

Is treatment being coordinated with a PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes; Name: _____	Is treatment being coordinated with a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes; Name: _____
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Section 4 DSM-IV Diagnostic Codes

Axis I (Include All):	Axis II:
Axis III:	Axis IV:
GAF: Current: _____ Highest In Past 12 months: _____	

Section 5 Medication

Is Member on current psychiatric and/or medical medications? If yes, please complete below. Use separate sheet if more space is needed.

MEDICATION	DOSAGE	RESPONSE	MEDICATION	DOSAGE	RESPONSE

Section 6 Symptom List (Check All That Apply)

a. Psychosis: <input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Loose Associations <input type="checkbox"/> Dissociation <input type="checkbox"/> Inappropriate Affect
b. Mood: <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Hypomania <input type="checkbox"/> Mania <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Concentration <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Loss of Motivation / Pleasure <input type="checkbox"/> Worthlessness / Guilt
c. Anxiety: <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Chronic Worrying <input type="checkbox"/> Obsessive Thoughts <input type="checkbox"/> Compulsive Behaviors <input type="checkbox"/> Hyper Vigilance <input type="checkbox"/> Phobia
d. Cognitive: <input type="checkbox"/> Dementia <input type="checkbox"/> Delirium <input type="checkbox"/> Distractible
e. Somatic: <input type="checkbox"/> G. I. <input type="checkbox"/> Pain <input type="checkbox"/> Conversion / Pseudoneurologic
f. Development Disorders: <input type="checkbox"/> Autism <input type="checkbox"/> Aspergers <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Other Learning Problems
g. Disruptive Behavior: <input type="checkbox"/> Oppositional/Conduct <input type="checkbox"/> Impulsivity <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Aggressive <input type="checkbox"/> Attention
h. Substance: <input type="checkbox"/> Abuse <input type="checkbox"/> Dependence (Specify Type) _____
i. Learning/School/Work Problems: _____
j. Other Symptoms (Specify) _____
k. Suicidal Ideation: <input type="checkbox"/> Yes <input type="checkbox"/> No Homicidal Ideation: <input type="checkbox"/> Yes <input type="checkbox"/> No Other Self Harm: <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 7 Treatment Type / Modality / Goals (Check All That Apply)

Type: <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group
Modality: <input type="checkbox"/> Cognitive Behavioral <input type="checkbox"/> Interpersonal (Including Family Systems Therapy) <input type="checkbox"/> Other (Specify): <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Support / Educational
Goals: <input type="checkbox"/> Behavior / Cognitive Change <input type="checkbox"/> Mood / Affect Change <input type="checkbox"/> Insight Into Problems <input type="checkbox"/> Environmental / Relationship Change <input type="checkbox"/> Supportive Treatment (Maintain Current Functioning) <input type="checkbox"/> Other (Specify):
Progress: <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Regressed

Section 8 Service Request

Requested Dates of Service:	CPT Code(s):
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Section 9 MHO Authorization

Authorization #:	Approved # of Visits:	Dates of Service:
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This is not a guarantee of benefits, only a review of the requested services for appropriateness and necessity. Reimbursement is based on the benefits available at the time of the service.

Signature : _____ Title: _____

*Please attach additional information, if necessary.