Molina Healthcare of Washington
2020 Behavioral Health Authorization/Notification Form
Phone Number: (800) 869-7185
Fax Number: (833) 552-0030

MEMBER INFORMATION

Plan: ☐ Medicaid ☐ Medicare ☐Marketplace Date of Request: _____ Admit/Start Date of Services: _____

Request Type: ☐ **Initial** ☐ **Concurrent** ☐ **Honor Authorization (Medicaid suspended)**

Member Name: _____DOB: _____

Member Molina ID#: _____Member Phone: _____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

*A service request designation is defined as Expedited/Urgent when the treatment requested is required to prevent serious deterioration of the member's health, or if not received could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.

PROVIDER INFORMATION

Name of Person/Facility sending request, Phone and Fax #:_____

Treating Provider/Name, Phone #, Fax # and Address: _____

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

Attending Psychiatrist/Prescriber Name (only if applicable): _____

UM Contact Name of referral source: _____UM Phone#/Fax#: _____

UM Contact Name of provider if different from referral source: _____UM Phone#/Fax#: _____

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

Requires Prior Authorization:	**Requires Notification and Concurrent Review:**
☐ Residential Treatment - MH & SUD (If LRA or CR, please include legal documents) ☐ Partial Hospitalization Program ☐ ABA Treatment (not testing) (Medicaid Only) ☐ Electroconvulsive Therapy (ECT) ☐ Transcranial Magnetic Stimulation (TMS) ☐ Psychological/Neuropsychological Testing ☐ Presumptive and definitive urinalysis drug testing (See page 2) (Medicaid Only) ☐ Non-PAR Outpatient Services ☐ Other – Describe: _____	☐ Acute Inpatient Hospitalization for behavioral health (Includes ASAM 4.0) ☐ Involuntary (Please include legal documents) ☐ Voluntary ☐ Withdrawal Management including Secure Detox (ASAM 3.7 or ASAM 3.2) ☐ Involuntary (Please include legal documents) ☐ Voluntary ☐ ASAM 3.7 ☐ ASAM 3.2 ☐ Crisis Stabilization in a residential setting

Procedure Code(s) and Description Requested: _____**Length of Stay Requested:** _____

Dates of Service Requested (Start and End Dates): _____

Primary Diagnosis Code for Treatment (including provisional diagnosis)	
Additional Diagnoses (including any medical diagnoses/conditons	
Psychosocial Concerns	

Together with this form, please fax pertinent, current clinical documentation to include presenting problems, assessments, medication administration records, and progress notes.

****For continued stay requests please submit clinical documentation from the most recently approved authorization date span.***

Progress toward Discharge/Aftercare Plan: Complete if member is in Inpatient Hospitalization)

Expected Discharge Date: _____ Follow-Up Appointment Scheduled: ☐ Yes ☐ No Date, if yes:_____

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

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

CLINICAL DOCUMENTATION INFORMATION

*****If providing these services or requesting services on behalf of a facility or provider, please submit this information. If applicable, provide rationale for utilizing out-of-network provider.*****

If requesting a service that requires additional information, please provide the appropriate clinical information with the request for review:

Applied Behavior Analysis (ABA) [Medicaid Only]:

- An ABA Level of Support Requirement form
- An Assessment and Behavior Change Plan prepared by the board-certified behavior analyst (BCBA
- A copy of a signed prescription for ABA therapy services
- A copy of the COE evaluation

Psychological and Neuropsychological Testing: *as covered per benefit package

- Diagnoses and neurological condition and/or cognitive impairment (suspected or demonstrated)
- Description of presenting 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?

Presumptive and definitive urinalysis drug testing [Medicaid Only]: Clinical notes are required for review and approval of your authorization request.

- CPT codes 80305, 80306, 80307 – PA required for more than 12 tests in any combination
- CPT codes G0480, G0481, G0482 and G0483 – PA required for more than 8 tests in any combination

Electroconvulsive Therapy (ECT): *as covered per benefit package

Acute/Short-Term:

- 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:

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

Transcranial Magnetic Stimulation (TMS)

- Current major depressive episode AND No psychotic symptoms (ECT is treatment of choice with psychotic symptoms)
- Adult ages 19 years or older, and
- Clinical Indications (One)
- Acute Symptoms refractory to treatment:
    - Failed trials of psychopharmacological agents
    - Antidepressant medications contraindicated

Non-PAR Outpatient Services: *as covered per benefit package

- Rationale for utilizing out-of-network provider
- Known or provisional diagnosis and current symptoms
- Plan of treatment including estimated length of care and discharge plan
- Additional supports needed to implement discharge plan

Inpatient, Withdrawal Management, Residential Treatment, Partial Hospitalization Program: *as covered per benefit package

- CURRENT (within past seven days) clinical information to include:
    - Acute Symptoms that warrant treatment or continued treatment at requested level of care
    - Treatment/interventions being provided to stabilize acute symptoms
- Include attending psychiatrist's notes (if applicable); therapy notes; assessments; nursing notes
- Include notes from prescriber and medication administration documentation including all med changes
- Current barriers to treatment at a less restrictive level of care
- Plan of care for discharge and transition into a lower level of care for continued treatment