MOLINA HEALTHCARE

Molina Healthcare of Wisconsin

OUTPATIENT OR DIVERSIONARY BEHAVIORAL HEALTH/SUBSTANCE ABUSE PRIOR AUTHORIZATION REQUEST

Phone Number: (888) 999-2404 FAX Number: (877) 708-2117

Service requested:

☐Intensive Outpatient ☐Partial Hospitalization ☐Day Treatment ☐ECT ☐Outpatient Therapy ☐In-Home Therapy ☐ Neuro/Psych Testing

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: ☐ Initial Request ☐ Updated Request		

Section 2 Provider Information

Provider rendering services (Include Degree):	Phone Number: ( )	Fax Number: ( )
Agency:	Address: (No., Street, City, State, Zip)	
EIN/TIN:		
Is treatment being coordinated with a PCP? ☐ Yes ☐ No If yes; Name: _____	Is treatment being coordinated with a psychiatrist? ☐ Yes ☐ No If yes; Name: _____	

Section 4 DSM-IV Diagnostic Codes

Axis I (Include All):	**Axis II:**
Axis III:	**Axis IV**:

GAF: Current: _____ **Highest In Past 12 months:** _____

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

a. Psychosis:	☐ Hallucinations	☐ Delusions	☐ Loose Associations	☐ Dissociation	☐ Inappropriate Affect	
b. Mood:	☐ Depressed Mood	☐ Hypomania	☐ Mania	☐ Sleep Disturbance	☐ Concentration	
	☐ Weight Loss/Gain	☐ Loss of Motivation / Pleasure		☐ Worthlessness / Guilt		
c. Anxiety:	☐ Panic Attacks	☐ Chronic Worrying	☐ Obsessive Thoughts	☐ Compulsive Behaviors		
	☐ Hyper Vigilance	☐ Phobia				
d. Cognitive:	☐ Dementia	☐ Delirium	☐ Distractible			
e. Somatic:	☐ G. I.	☐ Pain	☐ Conversion / Pseudonuerologic			
f. Development Disorders:		☐ Autism	☐ Aspergers	☐Mental Retardation	☐ Other Learning Problems	
g. Disruptive Behavior:		☐ Oppositional/Conduct	☐ Impulsivity	☐ Hyperactivity	☐ Aggressive	☐ Attention
h. Substance:		☐ Abuse	☐ Dependence	(Specify Type) _____		

i. Learning/School/Work Problems: _____

j. Other Symptoms (Specify) _____

_____

_____

k. Suicidal Ideation: ☐ Yes ☐ No **Homicidal Ideation:** ■ Yes ☐ No **Other Self Harm:** ■ Yes ☐ No

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

Date of initial visit/last visit:	Frequency:	# of visits being requested:	ELOS:	CPT Code(s):

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.*