Behavioral Health H0038 H2027 Authorization Request Form

H0038: Prior authorization required for services exceeding 200 units (units measured in 15 min increments) per member per calendar year

H2027: Prior authorization required for services exceeding 100 units (units measured in 15 min increments) per member per calendar year, beginning 1/1/25

Type of Request

- **H0038**
- **H2027**
- **Both**

End date extension of prior approval: Case #: **End date change to:**

Member Information

Member Name:	Member Medicaid ID#:
Member Date of Birth:	

Provider Information

Provider Name:	Provider NPI:	
Requestor Information:		
Name:	Phone:	Fax:

Dates for Services Being Requested	
Start Date:	
End Date:	

Code	Total # of Units for Requested Date Span
H0038	
H2027	

When submitting your request, the following information is required per Regulation AND clinical guidelines:

Medical Status; History of alcohol, tobacco, or other drug use, including any interventions; Acute intoxication and withdrawal potential; Current or history of psychological problems or psychiatric disorders and treatment received, including:

- Previous psychiatric admissions;
- History of suicidal or homicidal ideation and attempts;
- Outpatient psychiatric treatment; and
- Psychotropic medications;

OR

- biopsychosocial assessment and treatment plan*

Any legal proceedings; Psychosocial issues; Employment status Readiness to change; *Biopsychosocial assessment including:

- Diagnosis as made by a clinician operating within the clinician's professional scope of practice, in accordance with the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) for alcohol, tobacco, and other drug use;
- Screening for other co-occurring disorders;
- The ASAM level of care determination (if applicable); and
- Referral for a full diagnostic evaluation and treatment planning, if appropriate.

Treatment Plan including:

- Description of the services to be provided , including frequency.
- Measurable goals to achieve, including the expected date of the achievement for each goal
- Description of functional abilities and limitations, or diagnosis listed in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders
- Specify each staff member assigned to work with the individual
- Identify methods of involving family or significant others if indicated.
- Specify criteria to be met for termination of treatment
- Include the date schedule for review of the plan
- Creation of plan of care for individuals receiving substance use disorder treatment in accordance with the plan of care requirements set forth in KAR.

Any other pertinent information to support requested services:

Regulations: (Not all Inclusive)

Definitions

https://apps.legislature.ky.gov/law/kar/titles/907/015/005/

Coverage Provisions

https://apps.legislature.ky.gov/law/kar/titles/907/015/010/

General Requirements

https://apps.legislature.ky.gov/law/kar/titles/907/010/020/

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To submit your request to the UM Department :

- **UTILIZE AVAILITY TO SUBMIT YOUR REQUEST**
- **FAX THE CLINICAL REQUEST TO: (833) 454-0641**
- **CALL THE REQUEST: (800) 578-0775**

You may also utilize the Universal Fax form located on our Website