



Molina Healthcare of Mississippi  
 Marketplace Behavioral Health Prior Authorization Form  
 188 E. Capitol Street Jackson, MS 39201  
 Phone: 1-844-826-4335  
 Fax: (833)-322-1061

**Member Information**

Plan:  CHIP 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:  Mental Health  Substance Use

<input type="checkbox"/> <b>Inpatient Psychiatric Hospitalization</b> <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> <b>Subacute Detoxification</b> <input type="checkbox"/> Involuntary <input type="checkbox"/> Voluntary <input type="checkbox"/> If Involuntary, Court Date: ___ / ___ / ___	<input type="checkbox"/> Crisis Residential Treatment <input type="checkbox"/> Partial Hospitalization <input type="checkbox"/> Program Day Treatment <input type="checkbox"/> MYPAC <input type="checkbox"/> PRTF	<input type="checkbox"/> Electroconvulsive Therapy (ECT) <input type="checkbox"/> Psychological/Neuropsychological Testing <input type="checkbox"/> ABA for Autism Spectrum Disorder <input type="checkbox"/> Non-PAR Outpatient Services <input type="checkbox"/> Other – Describe: _____
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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"/> Appetite Changes               | <input type="checkbox"/> Impulsivity                                |
| <input type="checkbox"/> *Homicidal ideations/plan/attempt          | <input type="checkbox"/> Significant Weight Gain/Loss   | <input type="checkbox"/> Legal Issues                               |
| <input type="checkbox"/> *History of Suicidal/Homicidal actions     | <input type="checkbox"/> Panic Attacks                  | <input type="checkbox"/> Problems with Performing ADL's             |
| <input type="checkbox"/> Hallucinations/Delusions/Paranoia          | <input type="checkbox"/> Poor Motivation                | <input type="checkbox"/> Poor Treatment Compliance                  |
| <input type="checkbox"/> Self-Mutilation (ex. cutting/burning self) | <input type="checkbox"/> Cognitive Deficits             | <input type="checkbox"/> Social Support Problems                    |
| <input type="checkbox"/> Mood Lability                              | <input type="checkbox"/> Somatic Complaints             | <input type="checkbox"/> Learning/School/Work Issues                |
| <input type="checkbox"/> Anxiety                                    | <input type="checkbox"/> Anger Outbursts/Aggressiveness | <input type="checkbox"/> Substance Use Interfering with Functioning |
| <input type="checkbox"/> Sleep disturbances                         | <input type="checkbox"/> Inattention                    |   |

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

Medication Name	Dosage/ Frequency	New from	Date Current	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-Applied Behavior Analysis, and non-Par 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

**Applied Behavior Analysis: \*as covered per benefit package**

- Functional Assessment/Clinical Tool used for diagnosis
- Diagnosis (suspected or demonstrated)
- Member presenting symptoms and behaviors
- Parent or Caregiver involvement and training
- Provider Qualifications (experience with Autism Spectrum Disorder)
- Treatment plan including measurable goals and outcomes

**Non-PAR 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