Molina Healthcare of Washington

2025 Behavioral Health Admission Notification/Authorization Request Form

Phone Number: (855) 322-4082
Fax Number: (833) 552-0030

Date of Request: _____

MEMBER INFORMATION

Plan: ☐ Medicaid ☐ BHSO ☐ Honor Authorization (Medicaid suspended)
Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

☐ **Admission Notification**	☐ **Prior Authorization**	☐ **Concurrent Review**	☐ **Discharge Notification**
Admit Date: _____	Anticipated Start Date: _____	Last Covered Date: _____ Auth Number: _____	Discharge Date: _____

Member Name: _____ **DOB:** _____

Member Molina ID#: _____ **Member Phone:** _____

PROVIDER INFORMATION

Name of Person/Facility Sending Request: _____

Phone #: _____ **Fax #:** _____

Treating Provider/Name: _____ **Phone #:** _____

Fax #: _____ **Address:** _____

Treating Provider NPI or Tax ID number to be submitted with claim: _____

Facility/Provider Status:
☐ Contracted ☐ Out of Network (Please include page 3 with Prior Authorization request)

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

UM Contact Name of Provider if Different From Referral Source: _____

UM Phone #: _____ **UM Fax #:** _____

Member Court Ordered? ☐ Yes ☐ No ☐ In Process **Court Date:** _____

MOLINA HEALTHCARE

MENTAL HEALTH (MH) TREATMENT SERVICES	SUBSTANCE USE DISORDER (SUD) TREATMENT SERVICES
Acute Inpatient Hospitalization for Behavioral Health ☐ Involuntary (please include legal documents) ☐ Voluntary **Evaluation and Treatment** ☐ Involuntary (please include legal documents) ☐ Voluntary	**Withdrawal Management including Secure Detox** ☐ ASAM 3.7 ☐ ASAM 3.2 ☐ ASAM 4.0 Medical Detox ☐ Voluntary ☐ Secure Detox (Please Include legal documents) **Residential Treatment SUD** ☐ ASAM 3.5 ☐ ASAM 3.3 ☐ ASAM 3.3 PPW ☐ ASAM 3.1
☐ Intensive Behavioral Health Treatment Services (IBHT) ☐ Crisis Stabilization in a residential setting ☐ Residential Treatment-MH Is member on an** (please include legal documents): ☐ LRA ☐ CR ☐ N/A ☐ Partial Hospitalization (PHP) ☐ Intensive Outpatient (IOP) ☐ Electroconvulsive Therapy (ECT) ☐ Transcranial Magnetic Stimulation (TMS) ☐ Psychological/Neuropsychological Testing ☐ Other- Describe: _____	**Presumptive and definitive urinalysis drug & Breathalyzer testing (See page 4)** ☐ Presumptive - amount used this year: _____ ☐ Definitive - amount used this year: _____ ☐ Breathalyzer - amount used this year: _____ Other- Describe: _____

****For any ITA, LRA, Secure Detox or CR requests please include legal documents****

Procedure Code(s) and Description Requested: _____ **Number of Units/Days:** _____

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

Primary Diagnosis Codes for Treatment (including provisional diagnosis)	
Additional Diagnoses (including any medical diagnoses/conditions)	
Psychosocial Concerns (including housing status/needs)	

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.

*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.

MOLINA HEALTHCARE

BEHAVIORAL HEALTH OUT-OF-NETWORK AUTHORIZATION REQUEST

For out-of-network providers seeking prior authorization for services please include the following:

Member Name: _____

Member Molina ID #: _____ DOB: _____

☐ **Continuity of Care**	☐ **No Participating Providers Available**
How long have you been working with this member? What is unique to this member's condition or the services you provide that have prompted this request?	What services have been attempted within a 25 mile* radius of their residence? *50-mile radius for Marketplace.

Are you willing to finalize a single case agreement and bill Molina directly for services rendered? If so, provide business office/contracting contact.

Name: _____

Phone #: _____ Fax #: _____

Email: _____

☐ **We are willing to accept 100% of Medicaid Allowable rates for any medically necessary approved services and request a letter stating this.**

☐ We do not accept Medicaid rates and request a single case agreement for the requested services should they be approved.

Service Code: _____ Rate per Unit: _____

Service Code: _____ Rate per Unit: _____

Service Code: _____ Rate per Unit: _____

Information regarding allowable billing codes and rates can be found at: https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules

MOLINA HEALTHCARE

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:

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 and Breathalyzer testing: Clinical notes are required for review and approval of your authorization request.

Medicaid:

- CPT codes 80305, 80306, 80307 – Only one of the three presumptive codes may be billed per client per day.
    - CPT codes 80305 and 80306 – No PA for first 24 combined tests per year
    - CPT 80307 – PA required after 12 tests per year
- CPT codes G0480, G0481, G0482 and G0483 – PA required for more than 8 tests in any combination CPT
- CPT code 82075 – PA Required after 6 breathalyzer tests per year.

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 18 years or older, and
- Clinical Indications
- 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, Mental Health, Residential Treatment, Partial Hospitalization, Intensive Outpatient (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

Withdrawal Management and SUD Residential Services: Medical Necessity Review is required for continued services beyond the initial required approval period. Requests should include:

- CURRENT (within the past seven days) clinical to include:
    - SUD Assessment/ASAM Summary or Brief interval update to an existing assessment if older than 7 days.
        - Symptoms that warrant continued treatment at requested level of care
- Treatment Plan (this should include)
    - Interventions
    - Current barriers to discharge
    - Plan of care for discharge and transition to lower level of care for continued support

**** PA is required for all out-of-state SUD treatment**