Molina Healthcare of Texas
Behavioral Health Service Request Form
Phone Number: (866) 449-6849
Fax Number: (866) 617-4967

Member Information

Plan: ☐ Medicaid ☐ CHIP ☐ Medicare ☐ DUALS ☐ Marketplace

Date of Request: _____ Start Date/First Date of Service: _____

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone: _____

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

** Urgent/Expedited services are 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 elective/routine.*

Provider Information

Treatment Provider/Facility/Clinic Name: _____

Address: _____

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

Attending Psychiatrist Name (if applicable): _____

UR Contact Name: _____ UR Phone# _____ Fax#: _____

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

Service Requested

Service is for: ☐ Mental Health OR ☐ Substance Use

☐ **Inpatient Psychiatric Hospitalization** ☐ Involuntary ☐ Voluntary ☐ **Inpatient Detox Hospitalization** ☐ Involuntary ☐ Voluntary ☐ **Subacute / Residential Detox**	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ Day Program Intensive Outpatient Program	☐ Electroconvulsive Therapy (ECT) ☐ Psychological/Neuropsychological Testing ☐ Applied Behavior Analysis ☐ Non-PAR Outpatient Services ☐ Other – Describe below:

Procedure Code(s) and Description Requested. (***For OP, PHP, & IOP, please describe frequency of visits)***

Primary Diagnosis (including Provisional Diagnosis)	
Additional Diagnoses (including any known Medical Diagnoses /Conditions)	
Psychosocial Barriers	

Clinical Review - Initial and Concurrent

Functioning: Presenting/Current Symptoms that Necessitate Treatment or Continued Treatment. *Include safety/self-harm precautions, or substance withdrawal symptoms as applicable:*

***Please submit current (within the last 48 hours) Medical Progress Notes for Clinical Review** (inpatient only)*

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

Medication Name	Dosage/ Frequency	New from Admit?	Date Current Dose Initiated	Compliant?	Lab/Plasma Level?
		☐ New		☐ Yes ☐ No	
		☐ New		☐ Yes ☐ No	
		☐ New		☐ Yes ☐ No	
		☐ New		☐ Yes ☐ No	
		☐ New		☐ Yes ☐ No	

Aftercare Plans

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

Is treatment being coordinated with any other behavioral health practitioner? ☐ Yes ☐ No

If Yes, Name of Provider: _____ Last Contact Date with Provider: _____

If No, please explain:

What discharge planning or case management needs does the member have?

Any other information that would help us in reviewing your request?

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

- Diagnosis (suspected or demonstrated)
- Assessment/Clinical Tool used for diagnosis
- 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

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