Molina Healthcare of Mississippi
MississippiCAN Behavioral Health Prior Authorization Form
188 E. Capitol Street Jackson, MS 39201
Phone: 1-844-826-4335
Inpatient Request Fax: 1-844-207-1622
All Non-Inpatient Request Fax: 1-844-206-4006

Member Information

Plan: ☐ MSCAN 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 themember's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted asroutine/ 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

☐ **Inpatient Psychiatric Hospitalization** ☐ Involuntary ☐ Voluntary ☐ **Subacute Detoxification** ☐ Involuntary ☐ Voluntary ☐ If Involuntary, Court Date: ___/___/___	☐ Crisis Residential Treatment ☐ Partial Hospitalization ☐ Program Day Treatment ☐ MYPAC ☐ PRTF	☐ Electroconvulsive Therapy (ECT) ☐ Psychological/Neuropsychological Testing ☐ ABA for Autism Spectrum Disorder ☐ Non-PAR Outpatient Services ☐ Other – Describe: _____

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:

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Clinical Review - Initial and Concurrent

Functioning: Presenting/Current Symptomsthat Necessitate Treatment (or Continued Treatment)
*Denotes Documentation of Safety Plan Completed under Additional Information

- ☐ *Suicidal ideations/plan/attempt
- ☐ *Homicidal ideations/plan/attempt
- ☐ *History of Suicidal/Homicidal actions
- ☐ Hallucinations/Delusions/Paranoia
- ☐ Self-Mutilation (ex. cutting/burning self)
- ☐ Mood Lability
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Appetite Changes
- ☐ Significant Weight Gain/Loss
- ☐ Panic Attacks
- ☐ Poor Motivation
- ☐ Cognitive Deficits
- ☐ Somatic Complaints
- ☐ Anger Outbursts/Aggressiveness
- ☐ Inattention
- ☐ Impulsivity
- ☐ Legal Issues
- ☐ Problems with Performing ADL's
- ☐ Poor Treatment Compliance
- ☐ Social Support Problems
- ☐ Learning/School/Work Issues
- ☐ Substance Use Interfering with Functioning

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

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

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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