MOLINA HEALTHCARE

Molina Healthcare of Washington
2020 Behavioral Health
Authorization/Notifcation Form

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

MEMBER INFORMATION

Plan: ☐ Medicaid ☐ Medicare ☐ Marketplace

Date of Request: _____ **Admit/Start Date of Services:** _____

Request Type: ☐ Initial ☐ Concurrent ☐ Honor Authorization (Medicaid suspended)

Member Name: _____ **DOB:** _____

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

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

*A service request designation is defned 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 defnition should be submitted as routine/non-urgent.

PROVIDER INFORMATION

Name of Person/Facility sending Request: _____

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

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

Fax #: _____ **Address:** _____

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

Facility/Provider Status: ☐ PAR ☐ Non-PAR

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:** _____

Requires Prior Authorization:	Requires Notifcation and Concurrent Review:
☐ Residential Treatment - MH & SUD ☐ LRA ☐ CR For SUD Select: ASAM 3.5 ☐ ASAM 3.3 ☐ ASAM 3.1 ☐ ☐ Partial Hospitalization Program ☐ Electroconvulsive Therapy (ECT) ☐ Transcranial Magnetic Stimulation (TMS) ☐ Psychological/Neuropsychological Testing ☐ Presumptive and defnitive urinalysis drug testing (See page 2) Medicaid Only ☐ Presumptive ☐ Defnitive ☐ Non-PAR Outpatient Services ☐ Other – Describe: _____	☐ Acute Inpatient Hospitalization for behavioral health ☐ Involuntary (Please include legal documents) ☐ Voluntary ☐ ASAM 4.0 Medical Detox ☐ Evaluation and Treatment ☐ Involuntary (Please include legal documents) ☐ Voluntary ☐ Withdrawal Management including Secure Detox (ASAM 3.7 or ASAM 3.2) ☐ ASAM 3.7 ☐ ASAM 3.2 ☐ Secure Detox (Please include legal documents) ☐ Crisis Stabilization in a residential setting

*****For any ITA, LRA or CR request please include legal documents*****

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

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

Primary Diagnosis Code for Treatment (including provisional diagnosis)	
Additional Diagnoses (including any medical diagnoses/conditions	
Psychosocial Concerns	

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.

Progress toward Discharge/Aftercare Plan:

(Complete if member is in Inpatient Hospitalization)

Expected Discharge Date: _____

Follow-Up Appointment Scheduled: ☐ **Yes** ☐ **No** **Date, if yes:** _____

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

Provider Type	Provider Name	Telephone Number	Date of Appointment	Time of Appointment
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 beneft 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 defnitive urinalysis drug testing [Medicaid Only]: Clinical notes are required for review and approval of your authorization request.

- CPT codes 80305, 80306, 80307 – PA required for more than 12 tests in any combination
- CPT codes G0480, G0481, G0482 and G0483 – PA required for more than 8 tests in any combination

Electroconvulsive Therapy (ECT): (as covered per beneft package)

Acute/Short-Term:

- Acute symptoms that warrant ECT (specifc 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 19 years or older, and
- Clinical Indications (One)
- Acute Symptoms refractory to treatment:
    - Failed trials of psychopharmacological agents
    - Antidepressant medications contraindicated

Non-PAR Outpatient Services: (as covered per beneft 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, Withdrawal Management, Residential Treatment, Partial Hospitalization Program: (as covered per beneft 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