Authorization Request for Behavioral Health, Substance Treatment and Skilled Nursing and Residential Care

Submit this completed form by faxing it to 1-559-243-7012
or emailing it to **UMFax@healthcomp.com**.

Date of Request_____ Number of Pages in this Request_____

Our goal is to provide the most appropriate and timely care for our mutual patients. To this end, "Urgent" is defined as: Medical services that are needed in a timely or urgent manner that would subject the member to adverse health consequences without the care or treatment requested. Mountain Health Co-Op reserves the right to classify Urgent requests as standard requests when this definition is not met.

Patient Name_____ DOB_____ ID Number_____

Requested Level of Care

Start Date _____ End Date_____

Anticipated/Expected Length of Stay (Treatment)_____

☐ Inpatient Psychiatric Admission ☐ Inpatient Medical Detox/Chemical Dependency

☐ Residential Treatment (Psychiatric/Chemical Dependency) – Number of Beds _____

☐ Partial Hospital Program – Member will be attending _____days a week.

☐ Intensive Outpatient Program – Member will be attending _____days a week.

☐ Outpatient Treatment

☐ Skilled Nursing Facility ☐ Medical Residential Treatment

ICD 10	CPT/REV Codes	Units/Visits	Comments

Requesting Physician _____ NPI_____

Contact Name _____ Phone _____ Fax _____

Address _____

Service Rendering Hospital/Facility _____ NPI _____

Contact Name _____ Phone _____ Fax _____

Address _____ Tax ID _____

Note: Please submit clinical documents with time stamped note, signed by author.

Initial Request – Inpatient Admission/Residential Treatment

- ☐ Inpatient notification to include H&P and all applicable clinical
- ☐ COWS/CIWA/PAWS Scores
- ☐ Barriers to Discharge
- ☐ Admission note from Psychiatrist/Physician (If Applicable)
- ☐ Any adjustments or titrated medications being used
- ☐ Intake Assessment
- ☐ For **Out of Network** Providers/Programs: Copy of State License

Concurrent Review - Inpatient Admission/Residential Treatment

- ☐ Psychiatrist Note
- ☐ All therapy notes for applicable date span
- ☐ Any adjustments or titrated medications being used
- ☐ Updated Treatment Plan, Barriers to Discharge
- ☐ Why does the client continue to need 24 hour monitoring?
- ☐ Current CIWA/COWS Scores, Craving Score, Anxiety Score
- ☐ Current withdrawal symptoms
- ☐ Triggers identified
- ☐ Coping skills identified

Mountain Health Co-Op Medical Policies require that all facilities providing detox, Residential, PHP, and IOP level of care for Mental Health and/or Substance Use Disorder services, as well as Skilled Nursing and a Rehabilitation level of care for acute or chronic care services must meet minimum standards related to facility accreditation and Medical Director licensure.

Please complete and return the following information for your facility and Medical Director as soon as possible. This documentation is **mandatory** for continued consideration of services. Your cooperation is greatly appreciated.

I. Referral Requirement

Written referral from an in-network provider who has seen the member within 14 days of the referral.
**Please attach referral.*

II. Facility Accreditation

Facility must hold a JCAHO Accreditation:
*Please attach referral.

HCO ID: _____ Effective Date: _____

III. Medical Director Requirements

The attending physician must be Board Certified in Psychiatry by the American Board of Psychiatry and Neurology, Inc. (ABPN). This is **in addition** to state licensure.
Name and Credentials: _____

Certification Number: _____

Date Awarded: _____ Physican NPI: _____

The attending physician **must** be board certified in an area of skilled need of the facility and the patients being served.

Medical Director Certification: _____

Please fax the completed form and any supporting documentation to 1-559-243-7012 or 1-985-898-1505.
If you have any questions, please feel free to contact our Utilization Review department.