COMMUNITY MENTAL HEALTH CLINIC
PRIOR AUTHORIZATION REQUEST

Provider Information

1. Request Date ______________________________
2. Provider Name ______________________________
3. Provider ID No. ______________________________
4. Contact Name and Address
   (decision will be returned to this address)

   ____

   ____

   ____
5. Phone No. ______________________________
6. Fax No. ______________________________
7. E-Mail Address ______________________________

Recipient Information

8. Recipient Name ______________________________
9. Date of Birth ____________ 10. Recipient ID No. __________
11. Gender ☐ Male ☐ Female
12. Recipient Address ______________________________

    ____

    a. ☐ Private Home b. ☐ Foster Home
    c. ☐ Office of Children's Services Rehabilitation Home
    d. ☐ Transitional/Supported Living Home
    e. ☐ Residential Substance Abuse Treatment Center
    f. ☐ Homeless/Shelter g. ☐ Other-Explain: ______________
13. Type of Client: a. ☐ ED Adult b. ☐ SED Adult c. ☐ CMI Adult
    d. ☐ ED Child e. ☐ SED Child f. ☐ Other ______________
14. DSM: Axis I _________ Axis II _________ Axis III _________

15. ☐ **New Request** Requested Dates: From: ________________ Thru: ________________

16. ☐ **Update to existing PA** a. Update From: ________________ Thru: ________________ b. PA No. __________ (Required for PA updates only.)

Clinic Services	Code	Unit	17. Units Requested
Mental health assessment, by non-physician *[Intake assessment]*	H0031	15 min	______________
Psy dx interview *[Psychiatric assessment]*	90801*	1 assess.	______________
Intac psy dx interview *[Psychiatric assessment]*	90802*	1 assess.	______________
Psychological testing comprehensive assessment *[15 minutes/unit]*	CDBAQ#	15 min	______________
Neuropsychological testing *[15 minutes/unit]*	CDBAS#	15 min	______________
Crisis intervention mental health services, per hour	S9484	1 hour	______________
Group psychotherapy	90853*	30 min	______________
Family psytx w/patient	90847*	30 min	______________
Multiple family group psytx	90849*	30 min	______________
Psytx, office, 20-30 min	90804*	30 min	______________
Intac psytx, off, 20-30 min	90810*	30 min	______________
Medication management	90862*	1 visit	______________

Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.

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Revised 12/04//09

COMMUNITY MENTAL HEALTH CLINIC
PRIOR AUTHORIZATION REQUEST

Pages 1 and 2 of this request must be completed. Requests without both pages cannot be processed.

Provider Information

Request Date ______________________________

Provider Name ______________________________

Provider ID No. ______________________________

Contact Name______________________________

Contact Phone No. ______________________________

Recipient Information

Recipient Name ______________________________

Recipient ID No. ______________________________

Rehabilitation Services, Adult and Child	**Code**	**Unit**	**18. Units Requested**
Psychological testing brief assessment *[Functional assessment: 15 minutes/unit]*	CDBAP#	15 min	____________
Oral medication administration, direct observation *[on-premises]*	H0033	1 day	____________
Oral medication administration, direct observation *[off-premises]*	H0033 HK	1 day	____________
Social skills assistance, group *[Group skill development: 15 minutes/unit]*	CDAKQ#	15 min	____________
Social skills assistance, individual *[Individual skill development: 15 minutes/unit]*	CDAEP#	15 min	____________
Case management *[15 minutes/unit]*	T1016	15 min	____________

Rehabilitation Services, Child Only	**Code**	**Unit**	**19. Units Requested**
Family-involvement training, family *[Family skill development: 15 minutes/unit]*	CDABF#	15 min	____________

Recipient Support Services	**Code**	**Unit**	**20. Units Requested**
Coping Skills Development Assistance, Individual *[Recipient Support Services]*	CDACM#	15 min	____________

Current GAF Score ____________________ *(DBH review is required)*

Explanation: ____

____

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By submission of this form, the provider:

- affirms the assessment of the recipient's symptomatology and current level of functionality is documented in the recipient's record and indicates the units and duration of services requested are medically necessary;
- affirms the recipient's record includes documentation of the interdisciplinary team, physician, or mental health clinician recommendation of the requested services as medically necessary;
  - If the recipient is a severely emotionally disturbed child, the documentation must show that the interdisciplinary team reviewed the treatment plan and recommended the requested services as medically necessary.
  - If the recipient is a severely emotionally disturbed adult or a chronically mentally ill adult, the documentation must show that the recipient's mental health professional clinician or the recipient's physician reviewed the treatment plan and recommended the requested services as medically necessary; and
- acknowledges the services are subject to post-payment review for medical necessity and completeness of documentation according to Medicaid/Denali KidCare program rules. The Department of Health and Social Services may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medicaid/Denali KidCare program rules.

21. Clinic Signature ______________________________ Title ____________________

22. DBH Signature ______________________________ Date ____________________

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COMMUNITY MENTAL HEALTH CLINIC
PRIOR AUTHORIZATION REQUEST INSTRUCTIONS

Submission Requirements: This prior authorization (PA) form must be completed to indicate the amount of services requested beyond the service limitations set out in the Provider Billing Manual and must bear the signature of a person authorized to bind the requesting clinic. Requests that include **Recipient Support Services must be submitted to the Division of Behavioral Health (DBH)** for its review. DBH will forward the form to Affiliated Computer Services, Inc. (ACS) after its review. **Submit all other requests directly to ACS.**

Page 1:

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Provider Name:** Enter the name of the enrolled mental health clinic.
3. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the mental health clinic. If a clinic has multiple identification numbers, separate authorizations must be requested for each provider identification number (e.g., Day Treatment requests must be submitted on a separate form).
4. **Contact Name and Address:** Enter the name and address of the person ACS should contact regarding the authorization request. The authorization decision will be returned to the address entered here.
5. **Phone No.:** Enter the contact person's telephone number.
6. **Fax No.:** Enter the contact person's fax number, if applicable.
7. **E-Mail Address:** Enter the contact person's e-mail address, if applicable.
8. **Recipient Name:** Enter the name of the recipient for whom the authorization is being requested.
9. **Date of Birth:** Enter the recipient's date of birth.
10. **Recipient ID No.:** Enter the recipient's Medical Assistance identification number.
11. **Gender (recipient's):** Check appropriate box for male or female.
12. **Recipient Address:** Enter the recipient's address **and check the appropriate box** (a, b, c, d, e, f, or g).
13. **Type of Client:** Indicate by marking the appropriate designation for the client.
14. **DSM: Axis I**—Enter the primary DSM IV mental health disorder being treated. **Axis II**—Enter the DSM IV diagnosis being treated, if any. **Axis III**—Enter the medical condition, if applicable.
15. **New Request**—Mark this box if the prior authorization request is a request to initially exceed the annual service limits identified in the Provider Billing Manual. Enter the dates requested for the initial prior authorization. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
16. **Update to existing PA**—Mark this box when:
    - Requesting an update to add additional units of service to the existing PA record referred to in Field 16b.
    - Adding services not already included in the existing PA record referred to in Field 16b.
    - Extending the "thru" date of the authorization period for the existing PA record referred to in Field 16b.

    a. Update—Enter the "from" and "thru" dates for the authorization period being requested. Prior authorization requests will be accepted if requested for periods not to exceed 6 months and not to extend beyond the end of a calendar year.
    b. PA Number—Enter the number of the PA being updated.
17. **Units Requested (Clinic Services):** Enter the number of **additional units** of Clinic Services being requested.

Page 2: Enter the request date, Provider name and ID number, Contact person and phone number, recipient name, and ID number as entered on page 1. **If you do not enter this information, ACS may not be able to process your authorization.**

18. **Units Requested (Rehab. Services-Adult & Child):** Enter the number of **additional** units of Child or Adult Rehabilitation Services being requested.
19. **Units Requested (Rehab. Services-Child Only):** Enter the number of **additional** units of Child-only Rehabilitation Services being requested.
20. **Units Requested:** Enter the number of **additional** units of Recipient Support Services (RSS) being requested. Enter the client's current (past 7 days) GAF score. Your explanation must give 1) the specific staff involvement to be provided as RSS and 2) the symptoms and behaviors that support the GAF score.
21. **Clinic Signature:** The signature must be by a person authorized to bind the clinic to the completed form as accurate and subject to Medical Assistance program rules. Please include the title of the person signing the prior authorization request form.
22. **DBH Signature:** The DBH signature indicates DBH reviewed the form and may have discussed the request with the clinic staff for clarification. The signature does not indicate acceptance of the requested services or units as medically necessary. Medical necessity may be determined during a post-payment review according to Medical Assistance program rules. The division may recoup payment for any services that are not medically necessary, not properly documented, or not in compliance with Medical Assistance program rules.