



# MENTAL HEALTH PHYSICIAN CLINIC PRIOR AUTHORIZATION REQUEST

(See instructions on reverse side)

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### 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 \_\_\_\_\_  
\_\_\_\_\_

13.  **New Request**    Requested Dates: From: \_\_\_\_\_ Thru: \_\_\_\_\_
14.  **Update to existing PA**    a. Update From: \_\_\_\_\_ Thru: \_\_\_\_\_    b. PA No. \_\_\_\_\_

Clinic Services	Code	Unit	15. Units Requested
Mental health assessment, by non-physician [ <i>Intake assessment</i> ].....	H0031	15 min	_____
Psy dx interview [ <i>Psychiatric assessment</i> ].....	90801*	1 assess.	_____
Intac psy dx interview [ <i>Psychiatric assessment</i> ] .....	90802*	1 assess.	_____
Psychological testing comprehensive assessment [ <i>15 minutes/unit</i> ] .....	CDBAQ#	15 min	_____
Neuropsychological testing [ <i>15 minutes/unit</i> ] .....	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	_____
Individual psychotherapy; insight oriented.....	90806	1 hour	_____
Individual psychotherapy, .....	90812	1 hour	_____

By submission of this form the provider:

- affirms the assessment of the recipient's symptomatology and current level of functioning 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 physician or mental health clinician recommendation of 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.

16. Signature \_\_\_\_\_ Title \_\_\_\_\_

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## **Mental Health Physician Clinic Prior Authorization Request Instructions**

**Submission Requirements:** This prior authorization form is completed to indicate the amount of services requested beyond the service limitations set out in the Provider Billing Manual. Signature required is that of the person authorized to bind the requesting clinic. **Submit all requests directly to Affiliated Computer Services, Inc. (ACS).**

1. **Request Date:** Enter the date that the authorization request is being submitted.
2. **Provider Name:** Enter the name of the enrolled mental health physician clinic.
3. **Provider ID No.:** Enter the Medical Assistance identification number assigned to the mental health physician clinic.
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 recipient's address.
13. **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 exceed beyond the end of a calendar year.
14. **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 14b
  - Adding services not already included in the existing PA record referred to in Field 14b
  - Extending the "thru" date of the authorization period for the existing PA record referred to in Field 14b
  - 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 record being updated.
15. **Units Requested:** Enter the number of **additional units** of service being requested.
16. **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.