UnitedHealthcare Community Plan behavioral health prior authorization form for Washington Apple Health

Please only include medically necessary information and limit additional documentation to 4-8 page. When you complete the form, please fax to 844-747-9828.

If you have questions, please call **877-542-9231**.

Submitter information

Submitted date:	Submitted time:
Name:	Phone:

Member information

Member name: Last	First	Middle
Member date of birth:	Member ID number:	
Legal guardian: ☐ Yes ☐ No	Legal guardian name:	
Legal guardian phone:	Member primary phone:	
Member gender:	Member address upon discharge:	
Member city:	State:	ZIP:
Primary care provider (PCP) name:		
PCP phone:	PCP fax:	

Health care professional information

*Requesting facility information for initial only and if different from servicing facility/group

Requesting facility or group name:	
Requesting facility tax ID:	Requesting facility NPI:
Servicing facility or group name:	Servicing facility tax ID:
Servicing facility NPI:	

Health care professional information (cont.)

Service address (where member receives services):

City:	State:	ZIP:
Service facility phone:	Service facility fax:	

Attending physician name and phone (must be included for inpatient)

Attending physician name:	Attending physician phone:
Phone:	Fax:

Utilization reviewer name, phone & secure fax

Utilization reviewer name:	Utilization reviewer phone:

Utilization reviewer secure fax:

Authorization information

*If inpatient, follow-up appointment date and time must be within 7 days of discharge

Admission date:	Requested start date:

Member current location (in ER or elsewhere; please describe):

Last covered day (concurrent):	Authorization number (concurrent):
Choose one: ☐ Initial review ☐ Concurrent review	**Choose one:** ☐ Elective/routine ☐ Expedited/urgen

Current facility/in network or out of network health care professional:

Level of care/procedure code – Procedure code must match level of care

Inpatient mental health hospitalization	Court orders:
☐ Voluntary:	Fax court order to **888-821-5101**
☐ Involuntary:	Date of next court hearing:

☐ Single-bed certification case (SBC): Fax court order to 888-821-5101
Attach progress/results on placement in a psych unit.

☐ SUD WA Mandate HB 2642 Notification

Level of care/procedure code (cont.)

☐ Notification ASAM 4.0: (Acute setting)

WISE notification:	☐ CLIP notification
Residential treatment ☐ Short term mental health (MH) ☐ Long term MH ☐ Short term SUD American Society of Addiction Medicine (ASAM) 3.5 H0018 ☐ Long term SUD ASAM 3.3 H0019	Procedure code:
☐ **Residential treatment bed reservation** Bed date:	Procedure code:
Sub-acute (non-hospital setting) ☐ Clinically managed ASAM 3.2 H0010 ☐ Medically monitored ASAM 3.7 H0011	Procedure code:
☐ Partial hospitalization program/day	Procedure code:
☐ Electroconvulsive therapy (ECT)	Procedure code:
☐ Psychological testing	Procedure code:
☐ Non-par outpatient services	Procedure code:
☐ IOP (intensive outpatient)	Procedure code:
☐ Other:	Procedure code:

☐ Crisis stabilization/crisis triage services notification S9485

Clinical documentation instructions

1. Complete **all sections** below for inpatient, residential treatment, partial hospitalization, IOP or day treatment: *If SUD, **also** submit completed ASAM assessment - see end of fax for sample.
2. To protect PHI, please follow all HIPPA guidelines
3. Only include medically necessary documentation. Limit additional faxed documentation to 4-8 pages
4. Include with fax: Current attending psychiatrist's notes and medication
5. Do not fax extraneous or old chart documentation –

King County only: member-delegated SMI/SED? ☐ Yes ☐ No

Current primary DSM-5 diagnosis name and code:

Secondary DSM-5 diagnosis name and code:

Clinical documentation instructions (cont.)

Active medical conditions:

Precipitant/circumstances that led to admission:

Additional details about event(s) that led to treatment:

Was substance use a contributing reason for admission? ☐ Yes ☐ No If yes, details:

Current acute symptoms:

Psychosocial stressors and functional impairments:

Current living situation (including who they live with and support):

Current medications (can include list as attachment):

Barriers/issues related to medication regimen (Including non-compliance):

Current treatment interventions:

Specific actions or treatment plans to address acute symptoms or behaviors:

Planned discharge level of care:	Barriers to discharge:

Outpatient providers (prescriber, case manager and/or therapist):

Active medical conditions:

Psych testing, ECT, out-of-network additional clinical documention
To protect PHI, follow all HIPPA guidelines: Only include medically necessary documentation.

Don't fax extraneous or old chart documentation

Psychological testing:

- Diagnoses and neurological condition and/or cognitive impairment (suspected or demonstrated)
- Description of presenting symptoms andimpairment
- Member and family psych/medical history
- Documentation that medications/substance use have been ruled out as contributing factor
- Test to be administered and number 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

ECT therapy:

- 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

Out-of-network outpatient services: *as covered per benefit package

- Rationale for utilizing out-of-network provider
- Known or provisional diagnosis and current symptoms
- Any known barriers to treatment
- Plan of treatment including estimated length of care and dischargeplan
- Additional supports needed to implement dischargeplan

ASAM assessment

1. To protect PHI, follow all HIPPA Guidelines: Only include medically necessary documentation.
2. Do not fax extraneous or old chart documentation. Limit extra documentation to 4-8 pages
3. Address MAT considerations.
4. Succinctly address all ASAM dimensions and use this basic format or an ASAM dimension checklist
5. If you cannot complete the ASAM assessment due to member's condition please detail explanation. It might be more appropriate to call for a prior authorization in this instance.
6. If the assessment is within 2 weeks but not current, please send assessment and briefly update dimensions sections below or send in an addendum.
7. If the assessment is over 2 weeks old, redo the assessment.

ASAM dimension 1

(Acute intoxication or withdrawal potential)

Is the member currently on medication assisted treatment (MAT)? ☐ Yes ☐ No

Is continuing or initiating MAT contraindicated for the member? ☐ Yes ☐ No

MAT intervention based on federal guidelines for opioid treatment: Select

If other, please explain:

Substance use history (substance/amount/frequency/route/first use/last use):

Urine drug screen:	Blood alcohol level:

Current withdrawal symptoms/vitals:

History of seizures/blackouts/DTs:

Supporting assessment scores CIWA or COWS:

Assessor ASAM rating dimension 1:

ASAM dimension 2

(Biomedical conditions and complications)

Medical issues/diagnosis:

ASAM dimension 2 (cont.)

PCP:

Home meds:

Current meds/detox protocol:

Assessor ASAM rating dimension 2:

ASAM dimension 3

(Emotional, behavioral or cognitive conditions and complications)

Mental health diagnosis:

Outpatient mental health provider:

Home medications:

Current medications:

Other relevant information (e.g., abuse, trauma, risk factors, history of noncompliance, current mental status):

Assessor ASAM rating dimension 3:

ASAM dimension 4

(Readiness to change)

Stage of change/as evidenced by:

Internal/external motivators (legal, family, DCFS, employer, why now/precipitant):

Assessor ASAM rating Dimension 4:

ASAM dimension 5

(Relapse, continued use or continued problem potential)

Relapse potential:

Triggers identified:

ASAM dimension 5 (cont.)

Relapse prevention skills/progress during treatment:

Treatment history (levels of care, facility, dates):

Longest period of sobriety outside of structured environment:

Assessor ASAM rating dimension 5:

ASAM dimension 6

(Recovery and living environment)

Living situation:

Sober supports:

Family history of mental health/substance abuse

Assessor ASAM rating dimension 6:

*Effective Jan. 15, 2021.

United Healthcare® Community Plan