



Behavioral health only: Do not submit a medical prior authorization request to protect PHI. Follow all HIPPA guidelines. Only include medically necessary documentation. Limit additional documentation to 4-8 pages.

— Do not fax extraneous or old chart documentation —

Submitted date and time:	
Submitter name and phone:	
Member information	
Member first name:	Member last name:
Member DOB:	Member Medicaid ID:
Legal guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No	Legal guardian name & phone:
Member primary phone:	Member gender:
Member address upon discharge:	
Primary care provider (PCP) name:	
PCP phone:	PCP fax:
Provider 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:
Service address (where member receives services):	
City, state & ZIP code:	
Service facility phone:	Service facility fax:
Attending physician name and phone (must be included for inpatient):	
Utilization reviewer name, phone & 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):	
Expected discharge date:	
Last covered day (concurrent):	Authorization number (concurrent):
Choose one: Initial review <input type="checkbox"/> Concurrent review <input type="checkbox"/>	Choose one: Elective/routine <input type="checkbox"/> Expedited/urgent <input type="checkbox"/>
Current facility/provider PAR or non-PAR (in-network or out-of-network):	

Level of care/procedure code Procedure code must match level of care	
Inpatient mental health hospitalization Voluntary: <input type="checkbox"/> Involuntary: <input type="checkbox"/>	Court orders: Fax court order to 888-821-5101 Date of next court hearing:
Single-bed certification case (SBC): <input type="checkbox"/> Fax court order to 888-821-5101 Attach progress/results on placement in a psych unit.	
SUD WA Mandate HB 2642 Notification: <input type="checkbox"/>	
Notification ASAM 4.0: (Acute setting): <input type="checkbox"/>	
WISE notification: <input type="checkbox"/>	CLIP notification: <input type="checkbox"/>
Residential treatment Short term MH: <input type="checkbox"/> Long term MH: <input type="checkbox"/> Short term SUD ASAM 3.5 H0018: <input type="checkbox"/> Long term SUD ASAM 3.3 H0019: <input type="checkbox"/>	Procedure code:
Residential treatment bed reservation: <input type="checkbox"/> Bed date:	Procedure code:
Sub-acute (non-hospital setting) Clinically managed ASAM 3.2 H0010: <input type="checkbox"/> Medically monitored ASAM 3.7 H0011: <input type="checkbox"/>	Procedure code:
Partial hospitalization program/day: <input type="checkbox"/>	Procedure code:
Electroconvulsive therapy (ECT): <input type="checkbox"/>	Procedure code:
Psychological testing: <input type="checkbox"/>	Procedure code:
Non-par outpatient services: <input type="checkbox"/>	Procedure code:
IOP (intensive outpatient): <input type="checkbox"/>	Procedure code:
Other: <input type="checkbox"/>	Procedure code:
Crisis stabilization/crisis triage services notification S9485: <input type="checkbox"/>	

Clinical documentation instructions:

- 1 Complete **all sections** below for inpatient, residential treatment, partial hospitalization, IOP or day treatment:
*If SUD, **also** submit completed American Society of Addiction Medicine (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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current primary DSM-5 diagnosis name and code:
Secondary DSM-5 diagnosis name and code:
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? 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):	
Psych testing, ECT, out-of-network additional clinical documentation: To protect PHI, follow all HIPPA guidelines: Only include medically necessary documentation. – Do not fax extraneous or old chart documentation –	
Psychological testing: <ul style="list-style-type: none"> • 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 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 	

Electroconvulsive therapy (ECT):

- 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 discharge plan
- Additional supports needed to implement discharge plan

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.

American Society of Addiction Medicine (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:

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:
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:

<p>ASAM DIMENSION 4: (READINESS TO CHANGE) Stage of change/as evidenced by:</p>
<p>Internal/external motivators (legal, family, DCFS, employer, why now/precipitant):</p>
<p>Assessor ASAM rating Dimension 4:</p>
<p>ASAM DIMENSION 5: (RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL) Relapse potential:</p>
<p>Triggers identified:</p>
<p>Relapse prevention skills/progress during treatment:</p>
<p>Treatment history (levels of care, facility, dates):</p>
<p>Longest period of sobriety outside of structured environment:</p>
<p>Assessor ASAM rating Dimension 5:</p>
<p>ASAM DIMENSION 6: (RECOVERY AND LIVING ENVIRONMENT) Living situation:</p>
<p>Sober supports:</p>
<p>Family history of mental health/substance abuse</p>
<p>Assessor ASAM rating Dimension 6:</p>

*Effective Jan. 15, 2021.