Washington Apple Health IMC
UHC Behavioral Health Prior Authorization Form
Phone Number: (877) 542-9231
Fax Number: (844) 747-9828

UnitedHealthcare Community Plan

Washington Apple Health Integrated Managed Care BH Prior Authorization Request

Submitted Date and Time:	
Member Information	
Member First Name:	**Member Last Name:**
Member DOB:	**Member Medicaid ID:**
Legal Guardian: ☐ **Yes** ☐ **No**	**Legal Guardian Name & Phone:**
Provider Information	
Requesting Facility or Group Name:	**Requesting Tax ID:**
Admitting Facility or Group Name:	**Tax ID:**
Address 1:	**Address 2:**
City:	**State:**
Zip Code:	
Attending Physician *(must be included):	
Utilization Review or Contact Name:	**Utilization Review Contact Phone Number:** **Utilization Review Fax Number:**
Authorization Information	
Admission Date:	
Mbr Location (in ER or elsewhere; please describe):	
If Inpatient Expected Discharge Date:	**If Inpatient follow-up appointment Date and Time (must be within 7 days of Discharge:**
Choose one: **Initial Review:** ☐ **Concurrent Review:** ☐	**Choose One:** **Elective / Routine** ☐ **Expedited / Urgent** ☐
Number of Days / Units Requested:	
Level of Care / Procedure Code	
Inpatient Hospitalization: **Voluntary:** ☐ **Involuntary:** ☐	***Internal only (provider do not complete)***
If Involuntary – COURT DATE:	
Detoxification Notification ASAM 4.0: (Acute setting): ☐	***Internal only (provider do not complete)***
WISe Notification: ☐	***Internal only (provider do not complete)***
CLIP Notification: ☐	***Internal only (provider do not complete)***
Residential Treatment: **Short Term MH:** ☐ **Long Term MH:** ☐ **Short Term SUD ASAM 3.5 H0018:** ☐ **Long Term SUD ASAM 3.3 H0019:** ☐	**Procedure Code:**
Residential Treatment Bed Reservation: ☐ **Bed Date:**	**Procedure Code:**
Sub-Acute Detoxification (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:**

Clinical Information

Current Primary DSM-5 DX Code:	**Current Primary DSM-5 DX Name & Description:**
Secondary DSM-5 DX Code:	**Secondary DSM-5 DX Name & Description:**
Active Medical Conditions:	**Reason for Admission:**
What Current Uncontrolled Symptoms, risks or impairment require treatment on the request level of care?	**Progress Towards Goals (use additional page if needed):**
What specific actions or treatment plans are occurring to address acute symptoms or behaviors?	**King County Only: Is member delegated as SMI/SED** **Yes** ☐ **No** ☐
Planned Discharge Level of Care:	**Barriers to Discharge:**
Facility/Provider PAR or Non-PAR (in Network or Out of Network):	

CLINICAL DOCUMENTION

If requesting services on behalf of a facility or provider, provide this information. If requesting a service that requires additional information, also provide and attach appropriate clinical information with request for review:

Inpatient, Detoxification, Residential Treatment, Partial Hospitalization, IOP or Day Treatment: *as covered per benefit package. **If SUD, also submit completed ASAM Assessment – See end of fax for sample.*

- **CURRENT clinical information to include:**
  - Acute Symptoms that warrant treatment or continued treatment at requested level of care
  - Treatment/Interventions being provided to stabilize acute symptoms
  - Include Attending Psychiatrist's Notes; Nursing Notes; and Medication

Psychological Testing: *as covered per benefit package

- 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 # 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): *as covered per benefit package

- 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)

- o Personal and family psychiatric history (update needed for Continuation)
- o Medication review (update needed for Continuation)
- o Review of systems and Baseline BP(update needed for Continuation)
- o Evaluation by anesthesia provider (update needed for Continuation)
- o Evaluation by ECT-privileged psychiatrist (update within last month needed for Continuation)
- o Any additional workups completed due to potential medical complications
- o Continuation/Maintenance: *as covered per benefit package
- o Information updates as indicated above
- o Documentation of positive response to acute/short-term ECT
- o Indications for continuation/maintenance

Non-PAR Outpatient Services: *as covered per benefit package

- o Rationale for utilizing Out of Networkprovider
- o Known or Provisional Diagnosis and CurrentSymptoms
- o Any Known Barriers to Treatment
- o Plan of Treatment including estimated length of care and dischargeplan
- o Additional supports needed to implement dischargeplan

ASAM Dimensions

Submit completed ASAM assessment for SUD requests – ASAM Sample below:
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 Auth in this instance.

American Society of Addiction Medicine (ASAM) DIMENSION 1*: (ACUTE INTOXICATION OR WITHDRAWAL POTENTIAL)*

Substance use diagnosis:

Is MAT being considered? Y ☐ N ☐ N/A ☐

If Yes: MAT anticipated start date?
MAT Medication?

If No, why?

Has MAT been used in the past? Y ☐ N ☐ N/A ☐ UNK ☐

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:

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:

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: