AmeriHealth Caritas Delaware

Behavioral Health Prior Authorization Form

(Mental health inpatient, mental health partial hospitalization, and mental health intensive outpatient)

Submit to: Behavioral Health Utilization Management
Fax: 1-877-234-4273
For assistance, please call: 1-855-301-5512

Please note: Authorization is based on medical necessity. Incomplete or illegible forms will delay processing. Please provide all pertinent clinical information, including assessments and/or treatment plans. A telephonic review may be required if additional clinical information is needed to determine medical necessity.

Today's date:

REQUESTED SERIVCE		
☐ Mental health inpatient	☐ Precertification ☐ Continued stay	Date of admission: Estimated length of stay:
☐ Mental health partial hospitalization	☐ Precertification ☐ Continued stay	Service start date: Number of units per day: Number of days per week: Number of weeks requested:
☐ Mental health intensive outpatient	☐ Precertification ☐ Continued stay	Service start date: Number of units per day: Number of days per week: Number of weeks requested:

REQUESTED SERIVCE			
Name (last, first, MI):			
Date of birth:	Phone number:	Eligibility ID number:	
Address:			
Emergency contact:	Phone number:	Relationship:	
If dependent adult, legal guardian:		Phone number:	

Is this member currently in the PROMISE program? ☐ Yes ☐ No

Should the member be evaluated for the PROMISE program? ☐ Yes ☐ No

PROVIDER INFORMATION			
Facility name:			
Facility address:			
Facility NPI/tax ID:	Facility phone number:	Facility fax number:	
UM review contact name:	Attending physician:	NPI/tax ID:	

DIAGNOSES		
Primary diagnosis:	Secondary diagnosis:	Tertiary diagnosis:

MEDICATIONS

Home medications, if known, including dosages and prescriber (e.g., PCP or psychiatrist):

Name of current treating psychiatrist, if any:	Date last seen:

Medication name	Dosage	Frequency	Date of last change, if applicable	Type of change
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New

Additional information, if applicable:

CURRENT RISK AND LETHALITY		
Suicidal: ☐ No ☐ Yes — please answer questions below.		
Active recurrent thoughts: ☐ Yes ☐ No	Making threats: ☐ Yes ☐ No	Plan: ☐ Yes ☐ No
Available means: ☐ No ☐ Yes — please explain:		
Command hallucinations: ☐ No ☐ Yes — please explain:		
History of suicide attempts: ☐ No ☐ Yes — please explain:		
Homicidal thoughts: ☐ No ☐ Yes — please explain:		
Active recurrent thoughts: ☐ Yes ☐ No	Making threats: ☐ Yes ☐ No	Plan: ☐ Yes ☐ No
Available means: ☐ No ☐ Yes — please explain:		
Command hallucinations: ☐ No ☐ Yes — please explain:		
History of suicide attempts: ☐ No ☐ Yes — please explain:		
Assault or violence: ☐ No ☐ Yes — please explain:		
History of assault or violence: ☐ No ☐ Yes — please explain:		

MENTAL STATUS EXAM (INCLUDING APPEARANCE, EYE CONTACT, SPEECH, MOTOR ACTIVITY, THOUGHT PROCESS AND CONTENT, ORIENTATION, MOOD, AFFECT, AND HALLUCINATIONS): CHECK ALL THAT APPLY					
Appearance	☐ Neat	☐ Well-groomed	☐ Disheveled	☐ Dirty	☐ Drowsy
	☐ Intoxicated	☐ Casual			
Eye contact	☐ Adequate	☐ Intense	☐ Staring	☐ Avoidant	☐ Guarded
	☐ Poor	☐ Other:			
Speech	☐ Normal	☐ Soft	☐ Loud	☐ Slowed	☐ Slurred
	☐ Pressured	☐ Repetitive			
Interaction	☐ Pleasant	☐ Cooperative	☐ Angry	☐ Guarded	☐ Suspicious
	☐ Apathetic	☐ Aloof	☐ Passive		
Motor activity	☐ Appropriate	☐ Restless	☐ Hyperactive	☐ Repetitive	☐ Agitated
Affect	☐ Full range	☐ Flat	☐ Blunted	☐ Labile	☐ Contricted
	☐ Tearful	☐ Inappropriate			
Mood	☐ Calm	☐ Anxious	☐ Depressed	☐ Manic	☐ Hostile
	☐ Sad	☐ Euphoric			
Thought process	☐ Coherent	☐ Goal directed	☐ Blocking	☐ Loose associations	☐ Tangential
Thought content	☐ Coherent	☐ Suicidal	☐ Homicidal	☐ Hallucinations	☐ Grandiose
	☐ Delusional				
Orientation	☐ Oriented	☐ Person	☐ Place	☐ Time	☐ Disoriented

PRESENTING PROBLEM/CURRENT CLINICAL
Current clinical (SI, HI, psychosis, mood or affect, sleep, appetite, withdrawal symptoms, chronic substance use disorder [SUD]):
Describe member's functioning:
☐ Activities of daily living (ADLs):
☐ Social settings:
☐ Education and occupation:
☐ Current living environment:
☐ Indicate the recommendations of the member's assessment or evaluation and treatment plan:

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TREATMENT HISTORY AND CURRENT TREATMENT PARTICIPATION

Previous mental health/SUD inpatient, rehabilitation, and detox:

Outpatient treatment, psych testing, crisis intervention, community-based services:

Is the member participating in individual or group therapy? ☐ Yes ☐ No

Explain the member's clinical treatment plan:

How long has the member experienced mental illness and/or an SUD?

Family involvement or support system:

Substance use: ☐ Yes ☐ No
If yes and the member is in mental health inpatient, please explain how the SUD is being treated:

DISCHARGE PLANNING

Discharge planner name:

Phone number:	Fax number:

Place of residence upon discharge:

Address:

Treatment setting and services upon discharge:

Provider of services, if known:

Has a post-discharge seven-day follow-up aftercare appointment been scheduled? ☐ Yes (complete below)

Provider name: Date and time of appointment:

☐ No — please explain:

Identify collaboration needs. Please indicate if collaboration is needed with any of the below, including contact name and phone number:

☐ PROMISE program:

☐ Child or adult protective agency:

☐ Group home:

☐ Nursing or nursing home facility:

☐ Residential program:

☐ Jail, prison, or court system:

☐ LTSS or waiver programs:

☐ Other:

Provider signature:

Date: