



**Addiction and Recovery Treatment Services (ARTS)**  
**Service Authorization Review Form**  
**ASAM Levels 2.1/2.5/3.1/3.5/3.7/4.0**  
*No Service Authorization Needed for ASAM Level 0.5/1.0*

**Fax Form to Respective Health Plan Using Contact Information Below**

**PLEASE TYPE INFORMATION IN THIS FORM**

Supporting clinical information may be documented on last page or attached to this form.

**MEMBER INFORMATION**

Member Name:		DOB:
Member ID:	If retroactively enrolled, provide enrollment date:	

**PROVIDER INFORMATION**

Provider Group/Clinic:	Clinical Contact:
Street Address:	Physician Contact:
City   State   Zip:	Provider ID/NPI:
Phone:	Fax:

<b>ESTIMATED DURATION OF THIS EPISODE OF CARE:</b>	
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**ICD-10 DIAGNOSIS CODE(S)**  
 (Enter primary and any applicable co-occurring ICD-10 diagnosis codes)

1.	3.	5.
2.	4.	6.

**SUBSTANCE USE DISORDER TREATMENT HISTORY**  
 (Describe other ASAM Levels of Care utilized in past 12 months)

ASAM Level of Care	Name of Provider	Duration	Approximate Dates	Outcome

**MEDICATION**

Please list medications, dosage, frequency and prescribing practitioner below. Not applicable

Name of Medication	Dosage	Frequency	Prescriber

ASAM LEVEL OF CARE REQUESTED AND NUMBER OF UNITS (1 unit = 1 day)					
Code/Description Check Appropriate Code		Units	Code/Description Check Appropriate Code		Units
<input type="checkbox"/>	H0015 ASAM Level 2.1   Intensive Outpatient		<input type="checkbox"/>	H0010 / rev 1002 ASAM Level 3.5   Clinically Managed High-Intensity Residential Services (Adults)	
<input type="checkbox"/>	Rev 0906 ASAM Level 2.1   Intensive Outpatient		<input type="checkbox"/>	H0010 / rev 1002 ASAM Level 3.5   Clinically Managed Medium Intensity (Adolescent)	
<input type="checkbox"/>	S0201 ASAM Level 2.5   Partial Hospitalization		<input type="checkbox"/>	H0026 / rev 1002 ASAM Level 3.7   Clinically Managed High-Intensity Residential Services (Adults)	
<input type="checkbox"/>	Rev 0913 ASAM Level 2.5   Partial Hospitalization		<input type="checkbox"/>	H0026 / rev 1002 ASAM Level 3.7   Clinically Managed Medium Intensity (Adolescent)	
<input type="checkbox"/>	H2034 ASAM Level 3.1   Clinically Managed Low-Intensity Residential Services		<input type="checkbox"/>	H0011 / Rev 1002 Medically Managed Inpatient Services	
<input type="checkbox"/>	H0010 / rev 1002 ASAM Level 3.3   Clinically Managed Population-Specific High-Intensity Residential Services				

ASSESSMENT AND SCORING	
<b>DIMENSION 1   Acute Intoxication and/or Withdrawal Potential</b>	
<input type="checkbox"/>	No withdrawal (Move to the next dimension)
<input type="checkbox"/>	Moderate withdrawal symptoms not requiring 24-hour intensive or acute hospital setting (Possible referral to RTC)
<input type="checkbox"/>	Patient has the potential for life threatening withdrawal (Immediate referral to medically monitored detox)
<input type="checkbox"/>	Patient has life threatening withdrawal symptoms, possible or experiencing seizures or DT's or other adverse reactions are imminent (Immediate referral to acute hospital setting)
<b>Provide brief summary of the member's needs/strengths for Dimension 1:</b>	
<b>ASAM Level:</b>	
<b>Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).</b>	

**DIMENSION 2 | Biomedical Conditions/Complications**

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | None or very stable (OP)   |
| <input type="checkbox"/> | None or not sufficient to distract from treatment (IOP)  |
| <input type="checkbox"/> | None or not sufficient to distract from treatment (PHP)  |
| <input type="checkbox"/> | None/stable or receiving concurrent treatment – moderate stability (PHP/IOP/Other services)  |
| <input type="checkbox"/> | Severe instability requires 24-hour medical care in licensed medical facility. May be the result of life threatening withdrawal or other co-morbidity (Immediate referral to acute care) |

**Provide brief summary of the member's needs/strengths for Dimension 2:**

**ASAM Level:**

**Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).**

**DIMENSION 3 | Emotional/Behavioral/Cognitive Conditions**

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | None or very stable (OP)   |
| <input type="checkbox"/> | Needs structure to focus on recovery as these conditions can distract from recovery efforts (IOP/PHP)  |
| <input type="checkbox"/> | Moderate stability, cognitive deficits, impulsive or unstable MH issues (RTC)  |
| <input type="checkbox"/> | Severe instability high safety risk, very unstable may be related to substance use or in addition to substance requires 24-hour acute psychiatric care (Refer to inpatient services) |

**Provide brief summary of the member's needs/strengths for Dimension 3:**

**ASAM Level:**

**Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).**

**DIMENSION 4 | Readiness to Change**

<input type="checkbox"/>	Readiness for recovery but needs motivating and monitoring strategies to strengthen readiness, or needs ongoing monitoring and disease management (OP)
<input type="checkbox"/>	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment several times per week to promote change (IOP)
<input type="checkbox"/>	Has variable engagement in treatment, lack of awareness of the seriousness of substance use and/or coexisting mental health problems. Requires treatment almost daily to promote change (PHP)
<input type="checkbox"/>	Has marked difficulty with treatment or opposition due to functional issues or there has been ongoing dangerous consequences (RTC)
<input type="checkbox"/>	Poor impulse control, continues to use substances despite severe negative consequences (medical, physical or situational) and requires a 24-hour structured setting (Rehabilitation)

**Provide brief summary of the member's needs/strengths for Dimension 4:**

**ASAM Level:**

**Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).**

**DIMENSION 5 | Relapse, Continued Use or Continued Problem Potential**

<input type="checkbox"/>	Minimal support required to control use, needs support to change behaviors (OP)
<input type="checkbox"/>	High likelihood of relapse/continued use or addictive behaviors, requires services several times per week (IOP)
<input type="checkbox"/>	Intensification of addition and/or mental health issues and has not responded to active treatment provided in a lower levels of care. High likelihood of relapse, requires treatment almost daily to promote change (PHP)
<input type="checkbox"/>	Does not recognize the severity of treatment issues, has cognitive and functional deficits (RTC )
<input type="checkbox"/>	Unable to control use, requires 24-hour supervision, imminent dangerous consequences (Rehabilitation)

**Provide brief summary of the member's needs/strengths for Dimension5:**

**ASAM Level:**

**Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).**

**DIMENSION 6 | Recovery/Living Environment**

<input type="checkbox"/>	Supportive recovery environment and patient has skills to cope with stressors (OP)
<input type="checkbox"/>	Not a fully supportive environment but patient has some skills to cope (IOP)
<input type="checkbox"/>	Not a supportive environment but can find outside supportive environment (PHP)
<input type="checkbox"/>	Environment is dangerous, patient needs 24-hour structure to learn to cope (RTC)
<input type="checkbox"/>	Environment is imminently dangerous, patient lacks skills to cope outside of a highly structured environment (Rehabilitation)

**Provide brief summary of the member's needs/strengths for Dimension 6:**

**ASAM Level:**

**Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).**

**Space for additional documentation:** Not applicable

**SIGNATURE OF STAFF COMPLETING THE FORM**

<b>Name (print):</b>	
<b>Signature/Credential:</b>	<b>Date:</b>



**PLEASE SEND FORM TO THE DESIGNATED HEALTHCARE PLAN USING THE CONTACT INFORMATION BELOW**

**Please note a processing time for Inpatient Services – ASAM Level 4.0 is 24 calendar hours from receipt.  
All other ASAM Levels have 72 calendar hour processing time from receipt.**

CONTACT INFORMATION			
Managed Care Organization	Contact	Phone Number	Fax Number
Aetna Better Health	Stephanie Hargan	(800) 279-1878	(866) 669-2454
Anthem	N/A	(800) 901-0020 (for inpatient)	(877) 434-7578 (for inpatient) (800) 505-1193 (for outpatient)
INTotal Health	N/A	(855) 323-5588	(888)393-8978
Kaiser	Virginia Fancher Sue Leech Linda Bloch	(301) 625-6104 (301) 625-6103 (301) 625-6102	(855) 414-1703
Magellan	N/A	(800) 424-4046	N/A
Optima	N/A	(800) 648-8420	(844) 723-2096 (757) 431-7763
Virginia Premier Health Plan	N/A	(800) 727-7536 (toll –free) (804) 819-5151 (local)	(877) 739-1365

CONTACT INFORMATION			
Medicare-Medicaid Plan	Contact	Phone Number	Fax Number
Anthem Healthkeepers	N/A	(800)901-0020 (for inpatient)	(877)434-7578 (for inpatient) (800)505-1193 (for outpatient)
Humana Gold Plus Integrated	N/A	(855)765-9704	(804)765-9705
Virginia Premier Complete Care	N/A	(800)727-7536 (toll –free) (804)819-5151 (local)	(877) 739-1365