Member's Full Name: Medicaid #:

SERVICE AUTHORIZATION FORM

DAY TREATMENT/PARTIAL HOSPITALIZATION (H0035 HB) INITIAL
Service Authorization Request Form

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:	☐ Male ☐ Female ☐ Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
		Clinical Contact Name & Credentials*:	
		Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

Request for Approval of Services: **Retro Review Request?** ☐ Yes ☐ No

From _____ (date), To _____ (date), for a total of _____ units of service.
Plan to provide _____ hours of service per week.

Is this a new service for the member? ☐ Yes ☐ No (If no, then complete an authorization for continuing care.)

Primary ICD-10 Diagnosis	
Secondary Diagnosis	

Name of Medication	Dosage	Frequency

If additional medications are prescribed, include listing of medications, dosage, and frequency in the Notes section.

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SECTION I: DAY TREATMENT/PARTIAL HOSPITALZATION ELIGIBILITY CRITERIA	
Individual must meet <u>TWO</u> of the following; check applicable criteria on a continuing or intermittent basis:	
Has difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):	☐ Yes ☐ No
Exhibits such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary. Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior): Below identify all current/past treatment providers, whether they are currently in treatment with provider, treatment goals, and care coordination plan.	☐ Yes ☐ No
Exhibits difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior. ("Cognitive" does not refer to an individual with an intellectual or other developmental disability) Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):	☐ Yes ☐ No

Provider	Currently in Service?	Treatment Goals	Care Coordination Plan

SECTION II: CARE COORDINATION
Primary Care Physician:
Other medical/behavioral health concerns (including substance abuse issues, personality disorders, dementia, cognitive impairments) that could impact services? ☐ Yes ☐ No (If yes, explain below.) **Please indicate other current medical/behavioral services and additional community supports/interventions received:**

Name of service/treatment	Provider/Contact Information	Frequency

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Indicate plan to coordinate with primary care physician and other treatment providers/services to help ensure treatment interventions are coordinated:

SECTION III: TRAUMA-INFORMED CARE
Trauma-Informed Care (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)
Is there evidence to suggest this member has experienced trauma? ☐ Yes ☐ No
What is your plan to assess/refer and address the current and potential effects of that trauma?

SECTION IV: INDIVIDUAL TREATMENT GOALS
Treatment Goals: • Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. Include individual strengths/barriers/gaps in service, and written in own words of individual seeking treatment/or in a manner that is understood by individual seeking treatment. If individual has identified a history of trauma, please include trauma-informed care interventions in the treatment plan. • Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential. • Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress.
Resources and Strengths: Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports.
Please describe any barriers to treatment:
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific rehabilitative interventions will be provided to address this goal?

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How will you measure progress on the interventions provided?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific rehabilitative interventions will be provided to address this goal?
How will you measure progress on the interventions provided?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific rehabilitative interventions will be provided to address this goal?
How will you measure progress on the interventions provided?

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SECTION V: DISCHARGE PLANNING		
DISCHARGE PLAN (Identify lower levels of care, natural supports, warm-hand off, care coordination needs)		
Step Down Service/Supports	Identified Provider/Supports	Objectives to assist in transition
Recommended level of care at discharge:		

The Day Treatment/Partial Hospitalization Service Specific Provider Intake has been completed by the LMHP Type and the psychiatric history information reviewed. It is determined that the individual meets the Day Tx/PHP criteria.

Name of LMHP and Credentials **Date**

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NOTES SECTION
If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.

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PLEASE SEND FORM TO THE DESIGNATED HEALTH CARE PLAN USING THE CONTACT INFORMATION BELOW FOLLOWING THE TIME FRAME REQUIREMENTS ALSO BELOW

All MCOs rely on Contract Standards; 3 business days or up to 5 business days if additional information is required.

CONTACT INFORMATION			
Commonwealth Coordinated Care (CCC) Plus	Phone Number	Fax Number	Web Portal
Aetna Better Health of Virginia	855-652-8249	855-661-1828	https://www.aetnabetterhealth.com/virginia/providers/portal
Anthem HealthKeepers Plus	800-901-0020	866-877-5229	https://mediproviders.anthem.com/va/pages/precert.aspx
Magellan Complete Care of Virginia	800-424-4524	866-210-1523	Pending/TBA 2018
Optima Health Community Care	888-946-1168	844-348-3719 (BH Inpatient) 844-895-3231 (BH Outpatient)	www.optimahealth.com
United Healthcare	877-843-4366	855-368-1542	www.providerexpress.com
Virginia Premier Health Plan	844-513-4951	888-237-3997	Pending/TBA 4/1/2018

Community Mental Health Rehabilitation Services	Procedure Code	Registration vs. Authorization INTIAL REQUEST	Registration vs. Authorization CONTINUED STAY REQUEST
Mental Health Case Management	H0023	R	R
Mental Health Peer Support Services – Individual	H0025	R	A
Mental Health Peer Support Services – Group	H0024	R	A
Crisis Intervention	H0036	R	A
Crisis Stabilization	H2019	R	A
Intensive Community Treatment	H0039	A	R
Intensive In-Home	H2012	A	A
Therapeutic Day Treatment (TDT) for Children *TDT School Day	H0035 *HA	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Afterschool	H0035 *HA *UG	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Summer	H0035 *HA *U7	A	A
Day Treatment/ Partial Hospitalization *Adults	H0035 *HB	A	A
Mental Health Skill-building Services (MHSS)	H0046	A	A
Psychosocial Rehab	H2017	A	A
EPSDT Behavioral Therapy (ABA)	H2033	A	A

Timeframe Requirements for Submission (Concurrent)	CMHRS Services (excluding CI/CS)	CI/CS
Aetna	7 business days	48 hrs.
Anthem	14 business days	48 hrs.
MCC	7 business days	48 hrs.
Optima	7 business days	48 hrs.
United Healthcare	14 business days	48 hrs.
Virginia Premier	14 business days	48 hrs.