



SWHP Mental/Behavioral Health Authorization Request Form (Initial and Continued Care Treatment Review)

When completed with original signature, fax to SWHP HSD at: 1-800-626-3042 or 254-298-3450

(1) From _____ (2) Physician _____
 Physician _____ NPI # _____
 Or Provider (please print) _____
 (3) Phone _____ (4) Fax _____
 (5) Office Contact Person/Phone# _____
 (6) To: Physician/Provider _____
 Service Address _____
 City/State/ZipCode _____
 Phone _____ Fax _____
 (7) Date of Referral _____
 (8) Patient Name _____ Phone _____
 (9) Member Number _____
 (10) DOB _____ MRN: _____
 [Case ID #-if known: _____
 (11) Member's Current Location/Level of Care _____

(12) Request Status/Type
 _____ (Medically) Emergent
 _____ (Medically) Urgent
 _____ Routine
 _____ Elective/Pre-Authorization
 _____ Retrospective Review

Request Type
 _____ 23 Hr. Observation
 _____ Outpatient Only
 _____ Intensive Outpatient Program
 _____ Initial or Concurrent Inpatient
 _____ Day Treatment Program
 _____ Partial Hospitalization Program
 _____ Crisis Stabilization
 _____ Residential Treatment

(13) Medications:

Name	Dose	Frequency	Start	End
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(14) Diagnoses : Axis I _____
 Axis II _____
 Axis III _____
 Axis IV _____
 Axis V _____

(15) Procedure(s) Requested _____

(16) CPT Code(s) _____

Member Participation in Care: Poor Fair Good

(17) Next Appt. Date _____ (if known) (18) Number of Sessions To-date: _____

(19) # Requested Visits _____ over _____ (wks/mos.)*

(20) Date of Last Session: _____ (21) Estimated or Actual D/C Date: _____

(22) Service Requested by: Physician/Provider Member/Patient Other _____

(*Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent.) Note: While actual diagnostic or procedure codes are not required (only text descriptions), receipt of the actual codes that will be billed assists SWHP in more efficient processing of the requested services for a coverage determination in a timely manner to assist you later in prompt payment of any authorized services.

(23) Indication(s)/Justification for Requested Services* [Note: *Attach any pertinent information to assist SWHP in timely processing of the request. If requesting out-of-network services, justification for out-of-network referral, indicating the reason in-network service is not available/appropriate, is required in addition to the clinical indication for the service. Services are subject to coverage, benefit, network, and contract policies and exclusions. Members may be financially responsible for services they schedule themselves without a referral (if referral is required by their Evidence of Coverage or Standard Plan Document). Members also will be financially responsible if they receive non-covered benefits without required Plan pre-authorization. All services for tertiary and non-contracted providers or facilities must be prior authorized by SWHP.]

(24) Brief Summary of Current Clinical Status: _____

(25) List objective therapeutic goals for Member: _____

(26) List new objective goals for Member (if recertification): _____

(27) Criteria for Termination: _____

(28) Indicate if consultation with PCP has occurred:
 Yes, PCP notified of treatment plan PCP not contacted. Reason: _____

(29) _____ Signature of referring M.D. / Provider (no stamped signatures accepted)

- 1 **From Physician** - Physician who is requesting SWHP coverage of a service and/or providing a required notification.
- 2 **Physician Number** – National Provider identification number assigned to participating physician.
- 3 **Phone** - Requesting physician's phone number for the Plan to reach them on a routine basis.
- 4 **Fax** - Facsimile (FAX) phone number to physician's office (to return and/or request required information as needed).
- 5 **Office Contact Person/Phone#** - Referral Clerk and/or Office personnel that is facilitating request for MD/Provider
- 6 **To: Physician/Clinic plus Address** – name of physician, provider, hospital or clinic facility to which the referral or request is being directed (to include address, phone, and fax numbers for that entity-**required to process request**).
- 7 **Date of Referral** – actual date request or referral has been made by the requesting physician.
- 8 **Patient Name and Phone** – Actual Member's name that is to receive the services and current/working phone number where they can be reached.
- 9 **Member #** - Member's SWHP membership number
- 10 **DOB; MRN; and Case ID** – Date of Birth of the Member/Patient to receive the services; Member's Medical Record # (if known); Member's current SWHP Case ID (if known)
- 11 **Member's Current Location/Level of Care** – Member's current location at time request is faxed (i.e., at home waiting on answer; at facility; in physician's office; etc.) and level of care at the time of the request (i.e., in IP Care; Outpt. Care; IOP; Day Tx., etc.)
- 12 **Request Status/Type** – the **medical urgency** of request; **not** based upon scheduling/appointment access, unless underlying medical status warrants such **AND** identifies the type of level of request for service being submitted (i.e., such as Inpatient; Observation, Type of Program levels of coverage request)
- 13 **Medications** – List of significant medications that Member may be on that impacts the evaluation of this request
- 14 **Diagnosis/Diagnoses** – Member's principle diagnosis as the reason for consult/procedure and/or request for prior approval of a service. Axis Diagnosis is based on DSM-IV Codes (May include secondary diagnoses as appropriate.)
- 15 **Procedure(s)** – Actual tests and/or procedures requested to be performed
- 16 **CPT Codes** – Corresponding codes to the procedures listed in #15. **(Note: These are not required, but assist SWHP in timely processing of your request. If you are willing to provide the codes, it assists you later with more accurate claims payment related to the authorization.)**
- **Member Participation in Care** – If concurrent review or extension of service request, please note the participation level of the Member and compliance with the overall treatment plan
- 17 **Next Appointment Date (if known)** –Date services are scheduled to occur if already arranged
- 18 **# Sessions To-Date** – If request is for continued services, # of previous sessions/services rendered by the servicing provider
- 19 **# Requested visits/over time period** – Actual number of visits and the end date (or time period) by which the requested services are to be completed. **(Note: Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent. Services are subject to coverage, benefit, network, and contract policies and exclusions. Members also will be financially responsible if they receive non-covered benefits without required Plan pre-authorization. All services for tertiary and non-contracted providers or facilities must be prior authorized by SWHP.)**
- 20 **Date of Last Session** – Date Member was last seen by the provider requested to deliver services
- 21 **Estimated or Actual Planned D/C Date** – If planned series of treatments or defined program, the date of discharge for the Member tentatively planned
- 22 **Service Requested by** – Identifies the individual requesting the referral authorization (i.e., is the physician/provider requesting this service or facilitating a Member/Patient personal request OR is there some other source, such as another consultant, requesting the service)
- 23 **Indication(s)/Justification** - Physician's documentation of the medical necessity of the requested service **(may submit any pertinent information as an attachment faxed with this request form). (Note: clear and complete justification is required for any out-of-network request to prevent an inadvertent denial &/or delay to recontact provider for the information before the request can be processed.)**
- 24 **Brief Summary of Current Clinical Status** – Short statement(s) regarding current clinical status of the Member
- 25 **Objective Therapeutic Goals for the Member** – Goals to be accomplished with the Member if services/program approved
- 26 **New Objective Goals for the Member** – If continued care for recertification, what new goals are to be accomplished with continued care
- 27 **Criteria for Termination** – Critical Criteria/Goals that Member must meet to be able to complete services
- 28 **Consultation with PCP** – Indication of whether PCP (if not the referring physician) is aware of proposed treatment plan for their Member
- 29 **Signature of Referring M.D./Provider** – **ORIGINAL SIGNATURE REQUIRED of SWHP-Contracted Physician/Provider (matches to person in block #1) / No stamps or "initialed" signatures will be accepted.**