Texas Medicaid UnitedHealthcare Behavioral Health
Authorization Service Request Form
Fax Number: 844-280-1168

Texas Medicaid Behavioral Health Authorization Service Request

*Please use this form for behavioral health facility based care only. Do not use this form to submit a medical prior authorization request. To protect protected health information (PHI), follow all HIPPA guidelines. Only include medically necessary documentation. Limit additional documentation to **4-8 pages**, and please attach only what is requested. Fax the completed form to 844-280-1168.*

Submitted Date and Time:	
Submitter Name and Phone:	
MEMBER INFORMATION	
Member (Mbr) First Name:	**Mbr Last Name:**
Mbr DOB:	**Mbr Medicaid ID:**
Legal Guardian:	**Legal Guardian Name & Phone:**
Mbr Primary Phone:	**Gender: Male ☐ Female ☐ Other ☐ Unknown ☐**
Mbr Address Upon Discharge:	
Primary Care Provider (PCP) Name:	
PCP Phone:	**PCP Fax:**
PROVIDER INFORMATION	
**Requesting Facility information for initial only and if different from servicing.*	
Requesting Facility Name:	
Requesting Facility Tax ID:	**Requesting Facility NPI:**
Servicing Facility Name:	
Servicing Facility Tax ID:	**Servicing Facility NPI:**
Service Address *(where mbr receives services)* **:**	
City, State & Zip Code:	**Facility Status: In-Network ☐ Out of Network ☐**
Service Facility Phone:	**Service Facility Fax:**
Attending Physician Name and Phone:	
Utilization Reviewer Name, Phone & Secure Fax:	
AUTHORIZATION INFORMATION	
Admission Date:	**Requested Start Date:**
Initial Request: ☐ Concurrent/Extension: ☐	**For Initial Member Current Location:**
Non-Urgent: ☐ Urgent: ☐	**If Urgent, Clinical Reason:**
Last Covered Day (*for concurrent*)**:**	**Authorization number** (*concurrent)* :
Expected Discharge Date:	For PHP/IOP - **How Many Hours per Week**:
For PHP/IOP **- What days of the week are programming on: S ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ ST ☐**	
LEVEL OF CARE/PROCEDURE CODE	
Inpatient Mental Health: ☐ Code: **Voluntary: ☐ Involuntary: ☐** **If Involuntary - Court Date:** **If on a court order, fax court order to 888-821-5101*	**Inpatient Detox ASAM 4.0: ☐ Code:** **Residential Detox Sub-Acute Detox** *(non-hospital setting)* **ASAM 3.7 WM: ☐ Code:**
Residential Treatment **MH: ☐ Code:** **SUD ASAM 3.7 ☐ Code:** **SUD ASAM 3.5 ☐ Code:**	**Partial Hosp. Program (PHP): ☐ Code:** **Intensive Outpatient (IOP): ☐ Code:** **Outpatient Electro. (ECT): ☐ Code:** **Other: ☐ Code:**

Clinical Documentation Instructions:	
1. Complete all sections below of inpatient, detoxification, residential treatment, partial hospitalization or IOP (If substance use disorder (SUD), also submit complete ASAM Assessment). *2. To protect PHI, please follow all HIPPA guidelines & only include one member's information per fax.* *3. Only include medically necessary documentation and limit additional faxed documentation to 4-8 pages.* *4. Include with fax: Current medication list.* *5. Do not fax extraneous or old chart document.*	
INITIAL AND CONCURRENT REVIEWS	
Current Primary DSM-5 Diagnosis Name & Code:	
Secondary DSM-5 Diagnosis Name & Code:	
Active Medical Conditions:	
Precipitant/circumstances that led to admission:	
Additional details about event(s) that led to treatment:	
Was substance use a contributing reason for admission? *If yes, details* **:**	
Current Acute Symptoms:	
Psychosocial Stressors & Functional Impairments:	
Current Living Situation *(including who they live with and supports)* :	
*__Current Medication__ (*Can include list as an attachment)*	
Barriers/Issues related to Medication Regimen *including non compliance* :	
Specific Actions or Interventions to Address Current, Acute Symptoms or Behaviors:	
Discharge Plan *(including level of care):*	
Barriers to Discharge:	
Outpatient Providers (*prescriber & therapist*):	
DISCHARGE REVIEW	
**Discharges from IP Mental Health appointments must be within 7 days.*	
Member Location after Discharge:	
Date of Discharge:	**Follow-up appointment Level of Care:**
Provider Name:	**Provider Phone Number:**
Follow-up Appointment Date:	**Is this a Mental Health Provider:**

ADDITIONAL CLINICAL DOCUMENTATION FOR ECT & COGNITIVE DIAGNOSIS	
ELECTROCONVULSIVE THERAPY (ECT):	
Have there been Previous med trial failures:	
Is the member a child/adol, pregnant or have Presence of Dementia:	
Medically Cleared:	
Has a pre-ECT Global Cognitive Baseline Level of Functioning Completed:	
Previous ECT Treatment with Dates & Results:	
Requested Frequency & Anticipated Length:	
Date starting ECT:	**ECT # this treatment:**
ECT Treatment schedule (*days*)**:**	
Electrode Placement Unilateral/Bi-lateral:	
Seizure Duration in seconds:	**Seizure Considered Adequate:**
Adverse Effects from this ECT Treatment:	
Progress Addressing Precipitant *(concurrent):*	
Is Discharge Plan to attend OP ECT or Maintenance:	
Does Member Live within Geo Access to Attend OP ECT:	
Who will transport member to and from treatment and monitor them after:	
COGNITIVE DIAGNOSIS AND/OR AGE 65+	
Have you ruled out dementia/delirium:	
Has there been a medical hospitalization or surgery in the last 30 days:	
Have there been any medication changes in the last 30 days:	
Is the member currently taking any of the following medications: Steroids, Digoxin, Sinemet, Benzodiazepines or Antihistamines:	
Does the member have any abnormal labs, if Yes include results, (*e.g. BUN, WBC or Urine Leukocyte)* **:**	
Results of Cognitive Test and date *(e.g. Mini-Mental State Exam-MMSE or Montreal Cognitive Assessment-MOCA)* **:**	
Historical Cognitive Testing and/or Baseline:	

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) ASSESSMENT	
**Complete for all requests for member with primary SUD diagnosis.*	
ASAM DIMENSION 1: ACUTE INTOXICATION OR WITHDRAWAL POTENTIAL	
Substance Use Diagnosis:	
Is Medication Assisted Treatment (MAT) being Considered or used in the past:	
If Yes: MAT anticipated Start Date & Medication:	
If No: Why:	
SUBSTANCE USE HISTORY	
Substance 1:	**Amount:**
Frequency:	**Route:**
First Use:	**Last Use:**
Substance 2:	**Amount:**
Frequency:	**Route:**
First Use:	**Last Use:**
Other Substances:	
Urine Drug Screen Results & Date:	
Blood Alcohol Level & Date:	
Current Withdrawal Symptoms & Vitals:	
Clinical Institute Withdrawal Assessment for Alcohol (CIWA) score:	
Clinical Opiate Withdrawal Scale (COWS) score:	
History of Seizures/Blackouts/Delirium Tremens:	
ASAM Rating Dimension 1:	
ASAM DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS	
Home Medications:	
ASAM Rating Dimension 2:	
ASAM DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS	
Mental Health Diagnosis:	
Outpatient Mental Health Provider:	
ASAM Rating Dimension 3:	
ASAM DIMENSION 4: READINESS TO CHANGE	
Stage of Change *(e.g. contemplation, action or maintenance with details as evidenced by)* **:**	
Internal/External Motivators (*Legal, family, Dept. Child Family Services, Employer, Why Now*):	
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, facilities, dates)* **:**	
Longest Period of Sobriety Outside of Structured Environment & How Maintained:	
ASAM Rating Dimension 5:	

ASAM DIMENSION 6: RECOVERY AND LIVING ENVIRONMENT	
Living Situation *(with who and is it a sober environment* **):**	
Sober Supports:	
Family History of Mental Health/Substance Abuse:	
ASAM Rating Dimension 6:	