UnitedHealthcare Community Plan
BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST FORM
Residential and IOP

Admission Date: _______________ Estimated LOS: _______________ No. of Sessions Attended: _______________

Last Date of Use: _______________ UDS (date & results): _______________ Length of sobriety: _______________

Current Symptoms/Clinical Presentation; Withdrawal Symptoms; Risk of SI/HI (attach additional sheet, if necessary):

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Medications:

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Motivation for Treatment (Scale 1, lowest – 10, highest): _________

Participation in Treatment & Justification for Continuing at this Level of Care (as evidenced by):

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Biopsychosocial (Living Environment, Employment, Violence/Abuse, Community Supports, Functional Impairments):

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Family involved in Treatment? ____

Current Treatment Providers (Psychiatry, Psychology, Social Work, Case Manager or other Community Supports):

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AA Home Group: ☐ Y / ☐ N Sponsor? ☐ Y / ☐ N No. of Meetings Attended (Verified): ______

D/C Planning or Plans to Lower Level of Care: ____

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Please attach: Current Treatment Plan
Primary Counselor's Notes