

Mental Health Service Prior Authorization Request Form



COMMUNITY HEALTH PLAN
of Washington™

Fax form to: 206-652-7067
UM Department Phone: 800-440-1561

PLEASE TYPE or WRITE LEGIBLY
or request will be returned as unable to process

MEMBER INFORMATION

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

PROVIDER INFORMATION

Provider Group/Clinic:	Contact Name:
Phone:	Fax:
Street Address:	City State Zip:
Provider ID/NPI:	
AUTHORIZATION REQUEST START DATE:	
ESTIMATED DURATION OF THIS EPISODE OF CARE:	

DIAGNOSIS

(Primary and any applicable co-occurring diagnoses)

1.
2.
3.
4.

INSTRUCTIONS

This form must be submitted with the CA/LOCUS summary report. The documents are available to download on www.chpw.org (CALOCUS pg. 41 and LOCUS worksheet). Please attach the completed forms and supporting clinical documents to this form and submit together.

MEDICATION

Please list medications, dosage and frequency below. Not applicable

Name	Dosage	Frequency



CA/LOCUS LEVEL OF CARE BASED ON SCORE

<input type="radio"/> Level 3	<input type="radio"/> Level 5	<input type="radio"/> Other
<input type="radio"/> Level 4	<input type="radio"/> Level 6	

LEVEL OF CARE REQUESTED

<input type="radio"/> Level 3: Level 3: Structured Intensive Outpatient (IOP)	<input type="radio"/> Level 4: Partial Hospitalization (PHP)	<input type="radio"/> Other:
<input type="radio"/> Level 3-6: WISE	<input type="radio"/> Level 5: Residential Treatment	
<input type="radio"/> Level 4: PACT	<input type="radio"/> Level 6: Inpatient Hospitalization	

Is the CA/LOCUS recommended level of care different than what is requested? Yes No

If yes, please provide the reason for the variance and include supporting clinical documentation:

REQUESTED CODES
(Include Amount and Modifier)

Code	Units/ Visits	Modifier	Code	Units/ Visits	Modifier
<input type="radio"/> S9480 Intensive Outpatient, per diem (avg 3hrs/day, 3 days/week)			<input type="radio"/> Other Code: (please write)		
<input type="radio"/> H0018 Short-Term Residential (1-30 days)			<input type="radio"/> Other Code: (please write)		
<input type="radio"/> H0019 Long-Term Residential (31+ days)			<input type="radio"/> Other Code: (please write)		
<input type="radio"/> WISE (bundled services- codes must be billed with listed modifier)		U8	<input type="radio"/> Other Code: (please write)		
<input type="radio"/> PACT (bundled services- codes must be billed with listed modifier)		UD	<input type="radio"/> Other Code: (please write)		
<input type="radio"/> Inpatient Hospitalization			<input type="radio"/> Other Code: (please write)		

SIGNATURE

Reviewer Name (print):

Signature/Credential:	Date:
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