Mental Health Service Prior Authorization Request Form

COMMUNITY HEALTH PLAN of Washington™
The power of community

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

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CA/LOCUS LEVEL OF CARE BASED ON SCORE					
☐	Level 3	☐	Level 5	☐	Other
☐	Level 4	☐	Level 6		

LEVEL OF CARE REQUESTED					
☐	Level 3: Level 3: Structured Intensive Outpatient (IOP)	☐	Level 4: Partial Hospitalization (PHP)	☐	Other:
☐	Level 3-6: WISe	☐	Level 5: Residential Treatment		
☐	Level 4: PACT	☐	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
☐	S9480 Intensive Outpatient, per diem (avg 3hrs/day, 3 days/week)			☐	Other Code: (please write)		
☐	H0018 Short-Term Residential (1-30 days)			☐	Other Code: (please write)		
☐	H0019 Long-Term Residential (31+ days)			☐	Other Code: (please write)		
☐	WISe (bundled services- codes must be billed with listed modifier)		U8	☐	Other Code: (please write)		
☐	PACT (bundled services- codes must be billed with listed modifier)		UD	☐	Other Code: (please write)		
☐	Inpatient Hospitalization			☐	Other Code: (please write)		

SIGNATURE	
Reviewer Name (print):	
Signature/Credential:	**Date:**