AmeriHealth Caritas
District of Columbia

Behavioral Health Intensive Outpatient or Partial Hospitalization Authorization Request Form

When complete, please fax to 1-855-410-6638

Please type or print clearly. Incomplete and illegible forms will delay processing

Prior authorization is required for intensive outpatient and partial hospitalization services. For psychological and neuropsychological testing, please submit the Testing Outpatient Request Form. For outpatient requests, please submit the Behavioral Health Outpatient Treatment Request Form (OTR).

Electroconvulsive therapy (ECT) services must be prior authorized by telephonic review. Please call 1-877-464-2911.

Out-of-network providers: Prior authorization and a non-contracted provider form are required for all services.

1. Member information

Member name:_____ Medicaid number:_____

Social Security number:_____ Date of birth:_____ Phone:_____

Member address:_____ City, state:_____ ZIP:_____

Who referred member for treatment? ☐ Self ☐ Primary care provider (PCP) ☐ State agency:_____

☐ Other:_____ Name of referring agency:_____ Phone:_____

2. Treating provider information

Name (with credentials):_____

☐ National Provider Identifier (NPI) number:_____ ☐ In network ☐ Out of network ☐ In credentialing process

Phone:_____ Fax:_____

Address:_____ City, state: _____ ZIP:_____

Group name:_____ Group number:_____

Contact name:_____ Treating provider signature:_____

3. Reason for services

Primary reason or complaint:_____ Start date requested:_____

Services requested (service codes):_____ Frequency:_____

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4. Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis

List any and all DSM diagnoses (behavioral health and medical)

5. Please answer the following questions

1. Is the member currently participating in any vocational services? ☐ Yes ☐ No
2. Are the member's family or supports involved in treatment? ☐ Yes ☐ No
3. Has the member been evaluated by a psychiatrist? ☐ Yes ☐ No
4. Is there coordination of care with other substance use providers? ☐ Yes ☐ No
5. Is there coordination of care with other behavioral health providers? ☐ Yes ☐ No
6. Is there coordination of care with medical providers? ☐ Yes ☐ No

6. Medications

Is member on prescribed medications? ☐ Yes ☐ No

Prescribing physicians' names:_____

Is member compliant with medications? ☐ Yes ☐ No

Please list medications and dosages:_____

7. Treatment plan: Please attach the current treatment plan. Please include documentation related to progress on goals and any changes made as a result.

8. Assessment: Please attach the member's most recent assessment or an update on the member's symptoms.

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9. Treatment symptoms and considerations (please check all appropriate to member's clinical presentation)

- ☐ Assault within the last 24 hours
- ☐ Symptoms of psychosis (catatonia, auditory or visual hallucinations)
- ☐ Destruction of property within the last 24 hours
- ☐ Eating disorder symptom
- ☐ Fire setting within the last 24 hours
- ☐ Homicide attempt within the last 48 hours
- ☐ Homicidal ideation and high risk for attempt
- ☐ Mania-related symptoms (excessive motor activity, flight of ideas, grandiosity, pressured speech)
- ☐ Non-suicidal self-injury within the last six hours
- ☐ Social withdrawal
- ☐ Refusing treatment
- ☐ Suicidal ideation and risk for attempt
- ☐ Impaired judgment
- ☐ Supports that are unavailable or unable to provide required care and supervision
- ☐ The member having been an alleged perpetrator of abuse within the last month
- ☐ The member having been arrested or issued a restraining order due to domestic abuse
- ☐ Increasing social isolation or alienation
- ☐ Precipitating stressful life event within the last three months
- ☐ Inability to perform activities of daily living (ADLs) and not chronic in nature

10. Is the member cognitively able to participate in programing: ☐ Yes ☐ No
If no, please explain how the program will be implemented to meet the needs of the member:

11. Can the member adhere to safety plan or seek assistance during non-program hours: ☐ Yes ☐ No
If no, please explain how the member's safety will be assessed throughout the program:

12. Can the member participate in program groups: ☐ Yes ☐ No If no, please explain:

13. Does the member have impairment in primary roles (unemployment, not attending school, not going to work, inability to meet work expectations):

14. Does the member have transportation to attend the program? ☐ Yes ☐ No
If no, please explain how the member will attend the program:

15. Additional comments:

DHCF This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.
GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR