Mental Health Treatment Authorization Request

Please complete all fields below as indicated, select the appropriate level of care and attach relevant clinical documentation. **Fax the completed form and clinicals to 503-416-3713**.

Date of Request: _____

Member Information

Member name:_____ Member OHP ID#: _____

DOB: _____

Provider Information

Provider name: _____

Clinic name, if relevant: _____

Provider contact person: _____

Provider contact person email: _____

Contact phone#:_____ Contact fax#: _____

Stay/admit date: _____

Primary DSM 5 diagnosis and severity: _____

Delivering provider or clinic, if known (if not known, enter "TBD"): _____

Continued >>

Indicate Authorization Request Type

◯ Initial authorization request

OR

◯ Continued stay request (enter original authorization number):_____

OR

◯ Request for additional funding for non-expired existing authorization (enter original authorization number):

The following information must be submitted with your additional funds request. This may be entered below or included in supporting documentation:

* Number of additional sessions and codes: _____

* Explanation of the medical need for continued services:

* Clinical justification for the DSM 5 diagnosis that is a covered diagnosis on Oregon's prioritized list the member's condition and services that will be needed: ____

* Effectiveness of current interventions on members care plan objectives:

* If no improvement or treatment has not been effective, what will be done differently and what is expected to change/improve within the additional sessions?

*Individualized plan that includes the elements below:

☐ The expected benefit and outcomes from continued services

☐ Specific and measurable goal(s) of services

☐ Expected duration of the services

Please include the following documentation with each authorization request as indicated in the chart below

Current and valid Mental Health Assessment that includes:

- ☐ Clinical justification for the DSM 5 diagnosis that is a covered diagnosis on Oregon's prioritized list.
- ☐ Explanation of the medical need for the services.

Current and valid service plan that includes:

- ☐ Individualized plan that describes the member's condition and services that will be needed.
- ☐ Specific and measurable goal(s) of services.
- ☐ Expected outcome(s) and duration of the services.

A brief clinical reason for the request (entered here or as an attachment):

_____

Documentation Required	Documentation *Not* Required
◯ ABA Assessment	◯ Assessment FFS
◯ ABA Treatment	◯ General Outpatient FFS
◯ Intensive outpatient (IOP)	◯ Medication Management FFS
◯ Partial hospital (PHP)	
◯ Subacute treatment youth	**Outpatient Adult**
◯ Subacute treatment adult	◯ Level A adult
◯ Psychiatric residential treatment services (PRTS)	◯ Level B adult
◯ Psychiatric day treatment services (PDTS)	◯ Level C adult
◯ Transcranial Magnetic Stimulation (TMS) *Specify code(s) and units:*_____	◯ Level D adult/TAY (use ACT/ICM request for form Adult Level D/ICM)
◯ Psychological testing *Specify code(s) and units:* _____	**Outpatient Child**
◯ Electroconvulsive Therapy (ECT) *Specify code(s) and units:* _____	◯ Level A child
◯ Anesthesia for ECT	◯ Level B child
◯ Eating disorder residential	◯ Level C child
◯ Eating disorder partial hospitalization	◯ Community Based Intensive Treatment (CBIT)
◯ Eating disorder intensive outpatient	◯ Oregon intercept (Youth Villages)
◯ Level D child Initial HBS	
◯ Level D child HBS	