BEHAVIORAL HEALTHCARE OPTIONS, INC.℠

Fax request to: 702-341-7681
Questions? Call: 1-800-873-2246

Nevada Medicaid and Nevada Check Up
Outpatient & Behavioral Health Prior Authorization Request Form

☐ Outpatient Request ☐ Behavioral Health Request			REQUEST DATE:
REQUEST TYPE: ☐ Initial* ☐ Continued ☐ Unscheduled Revision			
*When submitting an initial request, enter the start date of services:			
RECIPIENT INFORMATION			
Name (Last, First, MI):			
Recipient ID:	DOB:	SSN:	
Address (City, State, Zip):			
Date of Eligibility Decision (for Retrospective Authorization requests only) :			
Recipient is in the custody of : ☐ Self ☐ Family ☐ Other (specify):			
RESPONSIBLE PARTY INFORMATION			
Name:		Phone:	
Address (City, State, Zip):			
Relationship to Recipient:			
PROVIDER / COORDINATING QMHP			
Name:		NPI / TIN:	
Phone:	Fax:		
Address (City, State, Zip):			
PRIMARY CARE PHYSICIAN			
Primary Care Physician Name:		PCP Telephone #:	
Treatment must be coordinated with the clients PCP. This will be accomplished by sending (choose): ☐ Treatment Plan ☐ Progress Notes ☐ Treatment Summary or Other (if other, specify in the space provided): Other Coordination:			
Is there a current signed Release of Information with the Primary Care Physician? ☐ Yes ☐ No			
BEHAVIORAL HEALTH SCREENING AND DSM MULTIAXIAL DIAGNOSIS			
Previous CASII/NECSET/LOCUS Score (for Continued Services request only):			
Current CASII/NECSET/LOCUS Score:		Date of Current CASII/NECSET/LOCUS:	
Intensity of Needs Level (1-6):			
Axis I	Primary Code:	Narrative:	
	Secondary Code:	Narrative:	
	Tertiary Code:	Narrative:	
Axis II			
Axis III			
Axis IV	Access to: ☐ Healthcare ☐ Economic ☐ Education ☐ Housing ☐ Legal ☐ Primary Support Group ☐ Occupation ☐ Social Environment Other (specify):		
Axis V	Current GAF/CGAS:	Highest GAF/CGAS in the last year:	

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CURRENT PSYCHOTROPIC MEDICATION(S) (Attach additional sheets if needed)		
Medication	Dosage/Frequency	Start Date
1.		
2.		
3.		
4.		
5.		
6.		

Is the recipient compliant with their medication(s)?: ☐ Yes ☐ No

Psychiatric History, Medical Concerns, and Other Pertinent Medical History (include allergies, co-morbid conditions, adverse reactions, and medication compliance issues):

Family Medical & Psychiatric History:

CURRENT TREATMENT

For each service that is currently being provided, enter the servicing provider name, daily units and frequency.

Service		**Servicing Provider Name, Daily Units and Frequency**
Rehabilitation Services	Peer-to-Peer Support	
	Basic Skills Training	
	Psychosocial Rehabilitation	
	Day Treatment	
	Crisis Intervention	
Outpatient Mental Health Care	Individual Psychotherapy	
	Family Therapy	
	Group Therapy	
	Intensive Outpatient	
	Partial Hospitalization	
	Medication Management	

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PREVIOUS TREATMENT
For each of the following services received within the last three years, describe the outcome and provide dates of service:
Psychiatric Inpatient Hospitalization:
Intensive Outpatient:
Residential Treatment:
Crisis Intervention:
Outpatient Mental Health:
Rehabilitative Services:
Other:

CURRENT RISK FACTORS

Please check all items that apply. When applicable, include additional information in the spaces provided.

☐ Suicidal Ideation ☐ Plan / Intent ☐ Attempts If so, how many and when? _____
☐ Homicidal Ideation ☐ Plan / Intent ☐ Attempts If so, how many and when? _____
☐ Dangerous (impulsive) behavior that place self/others/property, at risk ☐ Symptoms of psychosis
☐ Medical condition that complicates MH intervention ☐ History of non-compliance with treatment
☐ Elderly patient who Lives alone/no support system ☐ Patient on high dosage of anxiety/pain meds
☐ Child Abuse ☐ Elder Abuse ☐ Spousal Abuse ☐ Sexual Abuse ☐ Substance Abuse

Other risk factors:

CURRENT FUNCTIONING

Rate the effect of current symptoms on the following categories (do not leave any blanks):

0 = Not Applicable 1 = None 2 = Low 3 = Moderate 4 = High 5 = Severe

0 Marriage Relationship 0 Family 0 Job 0 School Performance 0 Intrapersonal

0 Household Activities 0 Friendship/Peers 0 Financial 0 Hobbies/Interests

0 Physical Health 0 Sexual Functions 0 Concentration

0 Sleeping Habits Describe sleeping pattern: _____

0 Eating Habits: ☐ Weight Loss? ☐ Weight Gain? Number of lbs.: _____ Timeframe: _____

Details:

TREATMENT PLAN*
Problem/Behavior #1:
Short Term Goal:
Long Term Goal:
Strengths and Psychosocial Support:
Progress or Regression During the Last Authorization Period **(For Continued Services Requests Only)**:
Problem/Behavior #2:
Short Term Goal:
Long Term Goal:
Strengths and Psychosocial Support:
Progress or Regression During the Last Authorization Period **(For Continued Services Requests Only)**:
Problem/Behavior #3:
Short Term Goal:
Long Term Goal:
Strengths and Psychosocial Support:
Progress or Regression During the Last Authorization Period **(For Continued Services Requests Only)**:
**** Use additional pages if necessary***

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DISCHARGE INFORMATION		
Service	**Discharge Criteria**	**Projected Resolution Date**
Peer to Peer		
BST		
PSR		
Day Treatment		
Individual Therapy		
Group Therapy		
Family Therapy		
Intensive Outpatient		
Partial Hospitalizations		

SERVICE LIMIT EXCEPTION REQUEST

Are you requesting units beyond the established limits for the recipient's current level of care?

☐ **Yes** ☐ **No**

If yes, attach progress notes for the last two weeks and complete the two questions below. Such services must be prescribed on the recipient's Rehabilitation Plan and may only be prior authorized up to 30 days. RMH services are intended to be short term services.

Provide a lifetime of the recipient's inpatient psychiatric admissions and residential treatment:

Provide a 90-day history of the recipient's most recent outpatient psychiatric services:

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REQUESTED SERVICES & AUTHORIZATION FORM	
Recipient Name:	Recipient ID:
Provider / Coordinating QMHP:	Fax:
Servicing Provider:	Fax:
Servicing Provider:	Fax:

Code	Modifier	Servicing Provider Name	NPI/API	Date Requested Approved	Start date and End Date	Units per day	Days per Week	Total Units	Authorization Number
1				Req. App.					
2				Req. App.					
3				Req. App.					
4				Req. App.					
5				Req. App.					
6				Reg. App.					

Provider / Coordinating QMHP Signature:	Date:

Date Received:	Date Referred to MD:	Determination Date:

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.