PRIOR AUTHORIZATION for MENTAL HEALTH SERVICES

For authorization, please complete this form, include patient chart notes, including CRISIS EVALUATION, to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490.

Section I: PATIENT INFORMATION

Date Requested:	Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Patient's Home Address:	Parent/Guardian Name *(if patient under 18)*:

Patient or Parent/Guardian Phone *(if patient under 18)*:	Patient or Parent/Guardian Email *(if patient under 18)*:
Primary Phone: ( ) Alternate Phone: ( )	

Section II: PROVIDER(S) INFORMATION

Facility Name:	Facility Address:

Facility NPI #:	Facility TIN #:	Contact Person:	Phone:	Facsimile:	Email Address:
			( )	( )	

Case Manager:	Phone:	Facsimile:	Email Address:
	( )	( )	

Section III: AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Date(s) of Service:	Place/Site of Service: *Please check*
☐ Auth Extension ☐ Pre-Auth ☐ Retro Auth ☐ Urgent	From: To:	☐ Ambulatory Surgical Center ☐ Inpatient ☐ Outpatient ☐ Home ☐ Office ☐ Telehealth

Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:

A. Type of Mental Health Services Requested: ☐ **Initial Request** ☐ **Additional Request**

1. ☐ Inpatient Mental Health
2. ☐ Inpatient Substance Abuse
3. ☐ Day Treatment / "Partial Hospitalization Program"
4. ☐ Eating Disorders Inpatient ***Use required "Eating Disorders-Inpatient Level of Care" form***
5. ☐ Eating Disorders Day Treatment ***Use required "Eating Disorders-Day Treatment-Intensive Outpatient Program Level of Care" form***
6. ☐ Eating Disorders Intensive Outpatient Therapy ***Use required "Eating Disorders-Day Treatment-Intensive Outpatient Program Level of Care" form***
7. ☐ Eating Disorders Residential Treatment Center ***Use required "Eating Disorders–Residential Level of Care" form***
8. ☐ Intensive Outpatient Therapy
9. ☐ Residential Treatment Center ***Use required "Psychiatric & Substance Abuse-Residential Level of Care" form***
10. ☐ Other (***please specify***): _____

B. ☐ Request for Inpatient Mental Health (IMH) or Inpatient Substance Abuse (ISA) Services: ***First Mental Health/Substance Abuse Admit?*** ☐ Yes ☐ No

1. **Request for IMH/ISA Admission:** Anticipated Admit Date: _____ Estimated Length of Stay: _____
   a. Type of Admission: ☐ Emergency Room ☐ Direct Admit ☐ Transfer from Outside Hospital (*Name of Outside Hospital:* _____)
   b. Type of Commitment: ☐ Voluntary ☐ Involuntary (☐ *Blue Sheet* ☐ *Pink Sheet* ☐ *White Sheet*)
2. **Request for Continued IMH/ISA Stay:** # of Additional Days Requested: _____ Target Discharge Date: _____

C. ☐ Request for Day Treatment (DT) / "Partial Hospitalization Program" (PHP):

1. **Request for DT/PHP Admission:** Anticipated Admit/Start Date: _____ Estimated Length of Stay: _____
   a. # of Full Program Days (6 hours or more/day) per Week: _____ b. # of Therapy Hours per Week: _____
2. **Request for Continued DT/PHP:** # of Additional Days/Weeks Requested: _____ Target Discharge Date: _____

D. ☐ Request for Intensive Outpatient Therapy (IOP):

1. **Request for IOP Admission:** Anticipated Admit/Start Date: _____ Estimated Length of Stay: _____
   a. # of Full Program Days (3 hours/day) per Week: _____ b. # of Therapy Hours per Week: _____
2. **Request for Continued IOP:** # of Additional Days/Weeks Requested: _____ Target Discharge Date: _____

E. ☐ Request for Other Mental Health Services: **DOS/Date of Service*

Service Description: _____ CPT/HCPCS: _____ DOS: _____

Service Description: _____ CPT/HCPCS: _____ DOS: _____

Service Description: _____ CPT/HCPCS: _____ DOS: _____

Additional Comments:

By submitting this form, I attest that the information provided is true and accurate to the best of my knowledge.

Please fax completed form, CRISIS EVALUATION, and medical records to 801-366-7449.