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

Name (Last, First MI):	DOB:	Age:	PEHP ID #:
Address:	Home Phone: ( )		Cell Phone: ( )

Section II: PROVIDER INFORMATION

Date Requested:		Facility Name:
Facility NPI #:	Facility Tax ID #:	Facility Address:
Contact Person:	Phone: ( )	Facsimile: ( )

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*
☐ Auth Extension ☐ Pre-Auth ☐ Retrospective Auth ☐ Urgent

Requested Date (s) of Service:

Type of Mental Health Service Requested: ☐ **Initial Request** ☐ **Additional Request**

☐ Inpatient Mental Health ☐ Inpatient Substance Abuse ☐ Day Treatment / "Partial Hospitalization Program" ☐ Intensive Outpatient Therapy

☐ Residential (*Salt Lake County & Box Elder School District Employer Group only*) ☐ Other (*please specify*): ____________________

Axis I Diagnosis/ICD-10 Code: *(include all)*		**Axis II Diagnosis/ICD-10 Code:**	
Axis III Diagnosis/ICD-10 Code: *(include primary & secondary)*		**Axis IV Diagnosis/ICD-10 Code:**	
Axis V (*GAF Score):	**Highest GAF score in past 12 months:**	****CIWA Score:** ☐ **N/A**	*****COWS Score:** ☐ **N/A**

A. ☐ **Request for Inpatient Mental Health or Substance Abuse Services:** **First Mental Health/Substance Abuse Admit?** ☐ Yes ☐ No

Admission Date: __________ Estimated Length of Stay: __________ Additional days being requested: ______ Target Discharge Date: __________

Type of Admission: ☐ Emergency Room ☐ Direct Admit ☐ Transfer from Outside Hospital (*Name of Outside Hospital:* ____________________)

Type of Commitment: ☐ Voluntary ☐ Involuntary (☐ *Blue Sheet* ☐ *Pink Sheet* ☐ *White Sheet*)

B. ☐ **Request for Intensive Outpatient Therapy (*non-residential treatment center*):**

Start Date: __________ # of sessions attended: ______ # of sessions requested: ______ Frequency: __________ Target Discharge Date: __________

C. ☐ **Request for Day Treatment / "Partial Hospitalization Program" (*non-residential treatment center*):**

Start Date: __________ # of days requested: __________ Frequency: __________ Target Discharge Date: __________

D. ☐ **Request for Residential Treatment:** **Benefit only available to Salt Lake County & Box Elder School District Employer Group when criteria met.*

Admission Date: __________ Estimated Length of Stay: __________ Additional days being requested: ______ Target Discharge Date: __________

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

Procedure/Service Description: ____________________ CPT/HCPCS: __________ DOS: __________

Procedure/Service Description: ____________________ CPT/HCPCS: __________ DOS: __________

Procedure/Service Description: ____________________ CPT/HCPCS: __________ DOS: __________

Additional Comments:

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

*GAF/Global Assessment of Functioning (Range 0-100; Score 0=inadequate information; 1-10=persistent danger; 91-100=no symptoms)
**CIWA/Clinical Institute Withdrawal Assessment of Alcohol (Score 0-9=absent or minimal withdrawal; 10-19=mild to moderate; > 20=severe)
***COWS/Clinical Opiate Withdrawal Scale (Score 5-12=mild withdrawal; 13-24=moderate; 25-36=moderately severe; > 36=severe)