Behavioral Health Authorization Request Form

Requests can be submitted electronically via the Provider Portal: https://smnyportal.valence.care

Fax completed form to: 1-866-865-9969

Phone number: 1-844-990-0255

*** = Required Information**

***Requestor's Contact Name:** ***Requestor's Contact Number:**

PATIENT INFORMATION

*Member Name: *Date of Birth:

*Member ID Number: Member Phone Number:

*Service is:
- ☐ Elective/ Routine
- ☐ Expedited/ Urgent *Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.*
- ☐ Extension to Authorization _____
- ☐ Continuity of Care Concern:

SERVICE TYPE

☐ Inpatient Mental Health	☐ Intensive Outpatient (IOP)	☐ Electro Convulsive Therapy
☐ Inpatient Chemical Dependency	☐ Outpatient Counseling	☐ Psych Testing
☐ Partial Hospitalization	☐ Residential Treatment Center	☐ Other:
	☐ Community Based Services/ Case Management	

PROCEDURE INFORMATION

***ICD-10** Diagnosis: Diagnosis Description:

*CPT Code: _____ Units: _____ CPT Code: _____ Units: _____ CPT Code: _____ Units: _____

CPT Code: _____ Units: _____ CPT Code: _____ Units: _____ CPT Code: _____ Units: _____

*** Date(s) of Service:**

PROVIDER INFORMATION

Ordering Provider: ☐ *Primary Care Physician*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ Phone _____

*Address:

Servicing Provider: ☐ *Same as Ordering*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ Phone _____

*Address:

Facility: ☐ *N/A*

*Name: _____ *NPI: _____ *TIN: _____

*Fax: _____ Phone _____

*Address:

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED & RETURNED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED.

LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION

Note: Utilization Management (UM) functions are performed by Evolent Health

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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CARE COORDINATION

UR Department	Discharge Planner	Health Plan Care Coordinator
☐ N/A	☐ N/A	☐ N/A
Name:	Name:	Name:
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:
Email:	Email:	Email:

MEDICATION

Is Member on current psychiatric and or medical medications? If yes, please complete below. Use separate sheet if more space is needed.

Medication	Dosage	Response	Medication	Dosage	Response

SYMPTOM CHECK LIST

(Not a substitute for submitting clinical information)

Psychosis:
☐ Command Hallucinations
☐ Hallucinations
☐ Delusions
☐ Dissociation
☐ Loose Associations
☐ Paranoia

Anxiety:
☐ Panic Attacks
☐ Chronic Worrying
☐ Obsessive Thoughts
☐ Compulsive Behaviors

Safety:
☐ Suicidal ideation
- ☐ Plan
- ☐ Intent
- ☐ Means

☐ Homicidal Ideation
- ☐ Plan
- ☐ Intent
- ☐ Means

☐ Property Destruction
☐ Aggression
- ☐ Verbal
- ☐ Physical

☐ Fire Setting
☐ Self-Harm

Mood:
☐ Depressed Mood
☐ Hypomania
☐ Mania
- ☐ Excessive Motor Activity
- ☐ Flight of ideas
- ☐ Grandiosity
- ☐ Pressured Speech

☐ Sleep Disturbance
☐ Weight Loss/Gain
☐ Hopelessness

Substance Use
☐ Abuse
☐ Dependence
☐ N/A

Detoxing Currently
☐ Yes ☐ No
☐ CIWA Score ____
☐ COWS Score____
☐ CINA Score ____
☐ History of withdrawal seizures
☐ History of delirium tremens
☐ Co-occurring medical condition
*If yes, list here
_____

Developmental Disorders:
☐ Autism
☐ Asperger's
☐ Mental Retardation
☐ Other

Medication Adherence:
☐ Yes
☐ No
If no, Name of Medication:
_____
Date Last Took:
_____

Other Symptoms:
☐ _____
☐ _____
☐ _____

Progress:
☐ Improved
☐ Unchanged
☐ Regressed

CLINICAL INFORMATION

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