Prior Authorization Request –
Behavioral Health Placement (BHIF/BHRF/TFC)
Fax Cover Sheet

Confidential

Date:	
To:	**Mercy Care Utilization Management; (844) 424-3976**
From:	
Agency:	
Fax #:	
Pages:	including cover sheet
Subject:	**PRIOR AUTHORIZATION REQUEST FOR CHILDREN AND ADOLESCENTS BHIF, BHRF & TFC**
LOC Being Requested: ☐ **BHIF** ☐ **BHRF** ☐ **TFC**	
Responding to Request for Additional Information ☐	**Auth Number:**
Attn:	

Prior Authorization Request must include the following and will not be reviewed unless packet is complete.

This fax transmission includes:

☐	Prior Authorization form including recommendations from Outpatient BHMP/ Medical director
☐	Detailed Discharge plan
☐	Most recent ISP
☐	Last 90 days of CFT notes, specifically including guardian consent for an out-of-home placement
☐	Most recent Comprehensive Assessment and CALOCUS (completed within last 30 days)
☐	Incident reports within the last 90 days detailing the severity and frequency of the behaviors.
☐	Documentation of treatment services currently in place or referrals made within the last 90 days.
☐	Clinical assessments, including Psychiatric evaluations, psychological evaluations, and psychosexual evaluations.
☐	Most recent psychoeducational assessment (IEP or 504 plan) including the IQ (found in MET)
☐	Sexually Maladaptive Behavior or Eating Disorder Addendum as needed

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*PLEASE NOTE THAT REQUESTS **WILL NOT** BE ACCEPTED UNLESS ALL SECTIONS ARE COMPLETED IN DETAIL WITH ALL SUPPORTING INFORMATION ATTACHED.*

Requested Level of Care: ☐ BHIF ☐ BHRF ☐ TFC		
Is the following being requested? ☐ Assumption of Funding ☐ Lateral Transfer ☐ TFC Modifier		
TFC Modifiers: ☐ UF - BH-PH CONDITIONS ☐ UG – BH COGNITIVE ☐ UH – PRIMARY PSYCHOTIC		
MEMBER DEMOGRAPHICS		
Member Name:		**DOB:**
AHCCCS ID:	**Health Plan:** ☐ ACC ☐ DCS/CHP ☐ DDD	
Current Status: ☐ T19 ☐ NT19 ☐ other primary/T19 secondary		**HB2442:** ☐
Current location of member: (i.e. inpatient, foster care, group home, family)		
Date of Admission:	**If inpatient, where was member prior:**	
BEHAVIORAL HEALTH HOME		
BHH Site Name & NPI:		**Fax:**
Requesting CM:	**Phone & Email:**	
Supervisor:	**Phone & Email:**	
Treating OP BHMP Name and Credentials:		
OP BHMP Phone & Email:		
Member's Last Attended BHMP Appointment:		
CHILD & FAMILY TEAM		
Legal Guardian:	**Legal Guardian Phone:**	
Legal Guardian Status: ☐ Bio Parent ☐ Adoptive Parent ☐ DCS ☐ TSS ☐ Other		
Other members of CFT: ☐ DCS ☐ JPO ☐ DDD ☐ ALTC/CRS ☐ Tribal Social Services		
Name & Contact Info for CFT Members checked above:		
CLINICAL INFOMATION		
Diagnosis: *Please be detailed including developmental disability/ substance use/abuse/dependence and medical/physical health diagnosis if applicable.* 1. 2. 3. 4. 5.		

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Reason for Referral: (check all that apply)

- ☐ Self-harming behaviors
- ☐ Substance Use
- ☐ Physical aggression
- ☐ Sexually Maladaptive behaviors *(if selected, addendum must be completed)*
- ☐ Eating Disorder *(if selected, addendum must be completed)*
- ☐ Other *(psychosis, homicidal, sexually reactive bxs, trafficking status)*

For each item checked, please provide examples within the last 90 days to include a clear explanation of why the individual requires an out-of-home placement and cannot be effectively treated in an outpatient setting.

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Current Psychiatric and Therapeutic Services Utilized Within the Last 90 Days: *Please provide the following information for each service the individual has used or has been referred for in the past 90 days:*

1. *Specific Name of Service(s): Example: Psychiatrist, therapist, counseling center, etc.*
2. *Referral or Intake Date: Please specify the date the individual was referred or first attended the service.*
3. *Frequency of Service: How often is the individual receiving this service? (e.g., weekly, bi-weekly, monthly)*
4. *Notes on Member's Progress or Barriers: Describe the individual's progress or lack of progress in treatment. Include any changes in their condition or behavior, improvements, setbacks, or any challenges (i.e no capacity) faced during the course of therapy or psychiatric treatment.*
5. *Date of all evaluations including psychiatric, psychosexual, psychological.*

Functioning: *Provide the member's full scale IQ (found in MET) and a description of their level of functioning in daily living tasks (e.g., personal care, communication, social interactions, household responsibilities).*

Does member utilize the following school accommodations? ☐ IEP ☐ 504 plan

Please provide most recent psychoeducational assessment including IEP or 504 plan.

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Behavioral Health Treatment Goals: *(specific, measurable, achievable, relevant, and time-bound goals to gain clarity for treatment for the level of care being requested)*
Tentative Discharge Plan*: Upon successful completion of the requested level of care, include the clinical team's aftercare plan including placement and treatment services to be provided.*
Plan A: **Plan B:**

Requesting CM:	**Signature/Date:**
CM Supervisor:	**Signature/Date:**

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THE FOLLOWING MUST BE COMPLETED BY OUTPATIENT BEHAVIORAL HEALTH MEDICAL PROFESSIONAL OR MEDICAL DIRECTOR

OP BHMP recommendation: I am ☐ IN AGREEMENT ☐ NOT IN AGREEMENT
for **REQUESTED LEVEL OF CARE:** ☐ BHIF ☐ BHRF ☐ TFC
Clinical opinion/rationale of OP BHMP for level of care being requested:
OP BHMP Name & Credentials
OP BHMP Signature:

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Disclaimer: *To ensure timely processing of this application, please provide a fully completed form along with all required clinical documents. This includes, but is not limited to, the following:*

- Last 90 days of CFT notes, specifically including guardian consent for an out-of-home placement *(applications may be closed without proper guardian consent).*
- Most recent Comprehensive Assessment and CALOCUS (completed within last 30 days)
- Incident reports within the last 90 days detailing the severity and frequency of the behaviors.
- Documentation of treatment services currently in place or referrals made within the last 90 days.
- Clinical assessments, including Psychiatric evaluations, psychological evaluations, and psychosexual evaluations.
- Most recent psychoeducational assessment (IEP or 504 plan) including the IQ (found in MET) is required for all OOH placements.
- Legal Involvement: to include charges and reason for JPO
- Sexually Maladaptive Behavior Addendum as needed
- Eating Disorder Addendum as needed

Failure to submit all necessary documentation outlining the individual's specific needs, as well as the services provided by the outpatient treatment team, may result in a denial of the application due to insufficient clinical documentation.

Sexually Maladaptive Behavior Addendum

Must be completed if requesting placement due to Sexually Maladaptive Behaviors

Please specify the current Sexually Maladaptive Behaviors that is needed to be addressed in treatment. *Must include the specific behaviors (i.e. grooming, penetration, inappropriate touch, beastiality), concerns, age of onset, frequency, and last known occurrence, dates.*

Was a Psychosexual evaluation completed? ☐ YES ☐ NO ☐ PENDING	**Date:**
Evaluating Provider & Agency:	

Please make sure to include psychosexual evaluation with additional documentation. If not able to provide copy of evaluation - please provide reasoning as to why.
Previous SMB services: *Please include types of services, exact dates of services and outcomes.*
Has member been adjudicated for SMB? ☐ YES ☐ NO
Date of Adjudication:
Probationary Terms:

Eating Disorder Addendum

Must be completed if requesting placement due to an Eating Disorder

Current height:	**Current weight:**
BMI:	**Amount of weight loss over last 3 months:**
Provide detailed explanation of eating disorder behaviors over the last 90 days:	
Weight trends over the last 90 days *(last 3 months of documented weight and BMI)***:**	
Past history of treatment for eating disorder (IOP, PHP, therapy, etc.):	
PCP Name & Phone Number:	
Date Last Seen by PCP:	**Is member medically stable?**
Current Medical Diagnosis:	
Current Medical Medications:	
Has member been hospitalized for medical reasons within the last three months:	
Please provide details of hospitalizations:	
Please attach current Labs and last medical progress note	