

# Outpatient Treatment Request for Substance Abuse Services

Submit within 10 calendar days of requested authorization start date (4:00 p.m. fax cut-off).

Please check if this is a resubmitted request in response to a request for more information.

If this is a reauthorization request, please attach a treatment plan with updates.

**When complete, please fax to 866.368.4562.**

## Member and Provider Information

Member name \_\_\_\_\_ ID # \_\_\_\_\_ Member SSN \_\_\_\_\_  
 Member address \_\_\_\_\_ Member DOB \_\_\_\_\_ Member phone \_\_\_\_\_  
 Provider name (as credentialed with Select Health) \_\_\_\_\_ Provider phone \_\_\_\_\_  
 Provider address \_\_\_\_\_ Provider fax \_\_\_\_\_  
 Contact person \_\_\_\_\_ Contact e-mail \_\_\_\_\_ Contact phone \_\_\_\_\_

Please complete the following:

	Y	N	DSM-IV Multiaxial Diagnosis <i>Please complete all 5 axes</i>
Signed release for CBHNP?			Axis I <input type="text"/> . <input type="text"/> / <input type="text"/> . <input type="text"/>
Communication with PCP or other relevant health practitioners about treatment?			Axis II <input type="text"/> . <input type="text"/> / <input type="text"/> . <input type="text"/>
In no, did member refuse?			Axis III
Other insurance, name(s) and policy number(s):	Axis IV <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
	Axis V: GAF Admission: Highest in past year: Current:		

CPT Code	Start date	If Reauthorization: # used prior auth	Description	Units Minutes	Units Issued	Providing professional, please print name & credentials below
90801			Psychiatric evaluation MD/DO	Event	1	
90806 (90804)			Individual psychotherapy	45-50	10	
90847			Family psychotherapy with member	15	40	
90853			Group psychotherapy	15	40	
90862			Pharmacologic management MD/DO	15	10	
H0034			Medication training & support, drug administration LPN/RN	15	10	
Other						

Comments:

**Member progress or status is required in each dimension as per ASAM**

Indicate level of care & criteria	Level of care	Criteria indicated	Symptoms, progress and status
Intoxication/withdrawal Dimension 1:			
Biomedical conditions Dimension 2:			
Emotional/behavioral Dimension 3:			
Tx acceptance/resistance Dimension 4:			
Relapse potential Dimension 5:			
Recovery environment Dimension 6:			

**Select Health use only**

<input type="checkbox"/> Incomplete request	<input type="checkbox"/> Valid request	Request faxed back to provider      Date of fax:
Authorization Date:	Authorization #:	Reason:
Date sent to PA for review:	PA MNC decision: <input type="checkbox"/> approve <input type="checkbox"/> deny	
If denied, date provider informed verbally:	Date denial letter sent:	