Select Health of South Carolina

Healthy Connections

Behavioral Health Outpatient Treatment
When complete, please fax to 1.888.796.5521.
Please type or print clearly. Incomplete and illegible forms will delay processing.

Participating Providers: prior authorization is only required for the following services: ECT* (90870), Environmental Intervention (90882), Interpretation of Results (90887), Unlisted Psychiatric Service (90899) and Psychological Testing (separate form, 96101, 96118).

ECT services must be prior authorized by telephonic review. Please call 1.866.341.8765.

Non-Participating Providers: prior authorization and a non-contracted provider form (available on the Select Health website) are required for all services.

1. MEMBER INFORMATION

Member name _____ Healthy Connections ID # _____ SSN _____ DOB _____

Member address _____ City, State Zip _____ Phone _____

Who referred member for treatment? ☐ Self/parent ☐ PCP ☐ School ☐ State agency _____ ☐ Other _____

Name of referring agent _____ Phone _____

2. TREATING PROVIDER INFORMATION

Name _____ ☐ MD ☐ Lic. Psychologist ☐ LIP   NPI # _____ ☐ PAR ☐ NON-PAR ☐ In Credentialing Process

Address _____ City, State Zip _____ Phone _____ Fax _____

Group name/Select Health ID # _____ Contact name _____ Treating provider signature _____

3. REASON FOR SERVICES

Primary reason/complaint _____ Start date requested _____

Services requested: Service code(s) _____ Frequency _____

4. DSM DIAGNOSIS

List all DSM diagnoses (behavioral and medical):

_____
_____
_____
_____
_____

5. PLEASE ANSWER THE FOLLOWING QUESTIONS

a) Is the member currently participating in any school services? ☐ Yes ☐ No

b) Is the member's family or supports involved in treatment? ☐ Yes ☐ No

c) Has the member been evaluated by a psychiatrist? ☐ Yes ☐ No

d) Is the member involved with SCDMH or DAODAS? ☐ Yes ☐ No

e) Is there coordination of care with other behavioral health providers? ☐ Yes ☐ No

f) Is there coordination of care with medical providers? ☐ Yes ☐ No

6. REASON FOR AUTHORIZATION OF NON-PAR PROVIDERS *(Utilization Management will contact provider directly before giving authorization)* ☐ N/A — provider is PAR

a) Specialty of provider to meet the needs of the member _____

b) Continuity of care concerns _____

c) Accessibility/availability of provider _____

d) Clinical rationale _____

7. MEDICATIONS

Is member on prescribed medication(s)? ☐ Yes ☐ No   Prescribing physician(s) name(s) _____

Is member compliant with medication(s)? ☐ Yes ☐ No   Please list medications and dosages _____

8. TREATMENT PLAN

Please attach the current treatment plan. Please include documentation related to progress on goals and any changes made as a result.

9. ADDITIONAL COMMENTS

_____
_____
_____
_____