South Carolina Department of Mental Health Community Mental Health Center (CMHC)
Treatment Review and Authorization Request

- ☐ Initial authorization/initial clinical assessment/plan of care (POC)
- ☐ Re-authorization/POC
- ☐ Routine request (up to 14 days)
- ☐ Expedited (within 72 hours): Services are needed to stabilize the patient and prevent deterioration. Client needs significant and immediate supportive interventions.

Admission date: _____ Date of request: _____

Managed care organization				
☐ **Select Health** Phone: 1-866-341-8765 Fax: 1-888-796-5521	☐ **Blue Choice** Phone: 1-866-902-1689 opt. 3 Fax: 1-877-664-1499	☐ **Molina** Phone: 1-855-237-6178 Fax: 1-866-423-3889	☐ **Absolute Total Care** Phone: 1-866-534-5976 Fax: 1-866-694-3694	☐ **WellCare** Phone (provider services and urgent requests): 1-888-588-9842 Fax: 1-888-343-5364

Provider information	
CMHC contact person:	Phone number: Fax number:
Ordering physician NPI number:	Phone number:

CMHC information		
Name:	Medicaid provider number:	NPI number:

Member information			
Name:	Date of birth:	DMH identification number:	Medicaid number:

Address:	Mobile phone number: Home phone number:	Contact information: Relationship: Phone number:

Current diagnoses

Psychiatric:

Medical: ☐ None ☐ As follows:
Co-occurring substance use disorder: ☐ None ☐ As follows:

Current medications (medication name, dosage, frequency, and prescriber):
☐ None ☐ Yes. See physician medical order (PMO).
Adherence to medication regimen: ☐ Not applicable ☐ See PMO

Justification for authorization: **(Be specific about describing symptoms, onset and duration of symptoms, level of functioning, and severity of the individual for whom services are being requested. If this is a re-authorization, also include progress in goals and objectives.)**

Expectation for client's improvement: **(Briefly describe how client is likely to benefit from the services requested or purpose of the treatment in relation to expected outcomes.)**

Previous and/or current treatment history and outcome: ☐ None ☐ Yes. See initial clinical assessment.

Discharge/transition plan: See attached POC. **Inpatient admission in the last 90 days:** ☐ None ☐ Yes

Significant changes in member's life since last assessment: **Date of last assessment:**
☐ None. This is an initial request for services. ☐ No significant changes
☐ Changes noted as follows:

Transportation available: ☐ Yes ☐ None Other barriers to treatment: ☐ None ☐ Yes:

Referral to clinical care coordination: ☐ Yes ☐ Not applicable

Overall motivation to treatment:

☐ Good — Willing to follow up with recommendations and actively participate in treatment

☐ Somewhat — Wants treatment, but sometimes forgets to complete action steps and plans or follow up with recommendations

☐ Poor — ☐Has or had difficulties following up with treatment because of poor insight

☐Not fully engaged or is ambivalent about the benefits of treatment

Family involvement: ☐ Active ☐ Limited ☐ None ☐ Not applicable

Explain any less than active involvement:

Participation in community supports: ☐ Not at this time ☐ As follows:

Other supports: ☐ None at this time ☐ As follows:

Treatment request

Please check services being requested and explain the program to be provided:

☐ **Behavior modification:** _____

1. Service code being requested: H2014 2. Number of units: _____ 3. Frequency: _____ (weeks)

☐ **Psychosocial rehabilitation services:** _____

1. Service code being requested: H2017 2. Number of units: _____ 3. Frequency: _____ (weeks)

☐ **Family support:** _____

1. Service code being requested: S9482 2. Number of units: _____ 3. Frequency: _____ (weeks)

☐ **Peer support:** _____

1. Service code being requested: H0038 2. Number of units: _____ 3. Frequency: _____ (weeks)

☐ **Community integration:** _____

1. Service code being requested: H2030 2. Number of units: _____ 3. Frequency: _____ (weeks)

Note: Services below only require re-authorization from Absolute Total Care, Molina and WellCare.

☐Individual TX: 1. Service code being requested 90832/90834/90837 2. Number of encounters ____ 3. Frequency: ____weeks

☐Family TX: 1. Service code being requested 90846/90847 2. Number of encounters _____ 3. Frequency: ____weeks

☐Group TX: 1. Service code being requested 90853 2. Number of encounters _____ 3. Frequency: ____weeks

Length of treatment: _____ Start date: _____ End date: _____ ☐ **Transition** ☐ **Continued stay**

Treatment review (complete only when requesting re-authorizations)

Number of appointments attended since last authorization: _____

Type of services and units/encounters used from last authorization:

☐ Individual TX _____ Number of encounters

☐ Family TX _____ Number of encounters ☐ Group TX _____Number of encounters

☐ Behavior modification _____Number of units ☐ Family support _____Number of units ☐ PRS _____Number of units

☐ Peer support services _____Number of units ☐ Community integration services _____Number of units

Other treating provider signature:	**Date:**