Prior Authorization / Behavioral Health Day Treatment Attachment (PA/BHDTA)

Instructions

Providers can find PA submission instructions in the ForwardHealth Online Handbook. For specific questions, call Provider Services at 800-947-9627.

Section 1 – Member information

1. Name – Member (Last, first, middle initial): _____

2. Date of birth – Member: _____

Section 2 – Documentation

3. Describe the length and intensity of the treatment request. All fields are required. Refer to the Behavioral Health Day Treatment service area of the Online Handbook for day treatment services hour limitations.

   Program request is for:

   _____ hours per day,

   _____ days per week,

   for _____ weeks,

   for a total of _____ hours.

4. Anticipated beginning treatment date: _____

5. Anticipated BHDT discharge date: _____

Section 3 – Service request

6. Select **one** type of service:
   - ☐ Substance use disorder (SUD) only
   - ☐ Co-occurring SUD and mental health
   - ☐ Mental health only

7. Indicate any additional complexities. Check all that apply.
   - ☐ Intellectual/development disability
   - ☐ Justice involved
   - ☐ Pregnant/postpartum
   - ☐ Under age 18

Section 4 – Assessment for substance use treatment

Complete this section for SUD only or co-occurring SUD and mental health service requests. This section is optional for mental health only requests.

8. List the diagnosed substance use conditions. (Enter up to three diagnoses and codes.)

   Primary diagnosis: _____ Code: _____

Secondary diagnosis: _____ Code: _____

Tertiary diagnosis: _____ Code: _____

9. Indicate the level of care based on the American Society of Addiction Medicine (ASAM) assessment. (Select **one** of the following.)
   - ☐ Outpatient services
   - ☐ Intensive outpatient services
   - ☐ Partial hospitalization services
   - ☐ Low-intensity residential
   - ☐ High-intensity residential
   - ☐ Medically monitored intensive inpatient
   - ☐ Medically monitored intensive outpatient

10. If the ASAM level of care is different from the requested treatment, provide a clinical reason why.

11. Indicate the member's medication-assisted treatment (MAT) status. (Select **one** of the following.)
   - ☐ Member is continuing an existing course of MAT.
   - ☐ Member will begin a course of MAT while receiving BHDT services.
   - ☐ Member has been informed of MAT and is refusing MAT at this time.

     Date of refusal: _____
     Note: The member's refusal must be documented in their record.
   - ☐ MAT is not recommended for this diagnosis. Provide diagnosis code: _____
   - ☐ MAT is not offered or made available at this facility.
   - ☐ Other MAT status: _____

12. Does the member have mental health symptoms?
   ☐ Yes ☐ No

   If yes, select the most appropriate description of the member's current situation:
   - ☐ Member has a current psychotropic medication regimen in place.
   - ☐ Member has been referred for a psychotropic medication evaluation.
   - ☐ Member has identified a need, and evaluation and treatment will be part of a BHDT plan.
   - ☐ Member has refused psychotropic medications.

Section 5 – Assessment for mental health treatment

This section is required for mental health only or co-occurring SUD and mental health service requests. This section is recommended for SUD only requests when the member has mental health symptoms.

13. List the diagnosed mental health conditions. (Enter up to three diagnoses and codes.)

Primary diagnosis: _____ Code: _____

Secondary diagnosis: _____ Code: _____

Tertiary diagnosis: _____ Code: _____

14. Indicate the assessment tool used. (Select **one** of the following.)
- ☐ Level of Care Utilization System (LOCUS)
  Score: _____
- ☐ Child and Adolescent Level of Care Utilization System (CALOCUS)
  Score: _____
- ☐ LOCUS-Child and Adolescent Service Intensity Instrument (CASII)
  Score: _____
- ☐ LOCUS-Early Childhood Service Intensity Instrument (ECSII)
  Score: _____
- ☐ Other: _____
  Score: _____
- ☐ No standardized assessment used.

Section 6 – Treatment

Complete this section for all service requests.

15. Select the planned treatment curriculum or program. Check all that apply.
- ☐ The Matrix Model
- ☐ Dialectical Behavior Therapy (DBT)
- ☐ Cognitive Behavioral Therapy (CBT)
- ☐ Cognitive Behavioral Therapy – Enhanced (CBT-E)
- ☐ Acceptance Commitment Therapy (ACT)
- ☐ Other: _____
- ☐ No specific curriculum or program

16. Date of treatment plan: _____

17. Date of continuing care plan: _____

Section 7 – Signature

Submitted by: _____

Date signed: _____

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