AlohaCare
For a healthy Hawaii.

BEHAVIORAL HEALTH
CONTINUING MENTAL HEALTH OUTPATIENT AND/OR CHEMICAL DEPENDENCY PRIOR AUTH REQUEST FORM

LOB: ☐ QUEST ☐ ACAP ☐ CD ☐ Dual DX ☐ Standard ☐ Retro

1. Provider/Facility: _____ Contact person: _____	☐ Big Island ☐ Maui ☐ Oahu ☐ Molokai ☐ Kauai ☐ Lanai	Phone:	Fax:	Request Date:

2. Member Name: _____ **Member ID:** _____ **DOB:** ____/____/____ **Age:** _____

3. DSM/ICD 10 Diagnostic Codes:

Primary: _____

Secondary: _____

4. Medical Conditions:

_____

5. Z Codes: Please check areas of concern (if applicable):

☐ Primary Support Group ☐ Legal System/Crime ☐ Housing ☐ Economic
☐ Social Environment ☐ Occupational ☐ Access to Care ☐ Educational

6. Level of Care Requested:

☐ Social Detox ☐ Res Maintanance ☐ PHP ☐ IOP ☐ LIOP ☐ OPS ☐ Methadone

7. Requested # of Sessions: _____ **From:** _____ **To:** _____

8. Required Documentation: Please submit required clinical notes for either 6A or 6B as listed below:

A. **Outpatient Mental Health:** ☐ Clinical Summary ☐ Behavioral Contract (if applicable)

B. **Chemical Dependency/Dual Diagnosis:** ☐ UA results ☐ Behavioral Contract (if applicable)

9. If this is a Retro-request please explain why:

10. Current Medications: (psychiatric/other)

Medication	Dose	Frequency	Start Date	Prescriber

Does member require an interpreter? ☐ Yes ☐ No **If yes, what language:** _____

Is Care Coordination requested: ☐ Yes ☐ No **(If yes, please explain):** _____

QUEST only: Potential SMI/SPMI/SEBD: ☐ Yes ☐ No

CLINICAL INFORMATION: (Please complete the following)

1. Please explain why member continues to require this Level of Care:

_____

_____

2. Did member attend all scheduled sessions? ☐ Yes ☐ No If No, please list dates and reasons for non-attendance:

_____

_____

3. Date of most recent UA: _____ Results: _____

If UA was not done, please explain why:

_____

_____

4. Is member on a Behavior Contract? ☐ Yes ☐ No If yes, please explain why and attach a copy:

_____

_____

5. Does member attend any sober support meetings? ☐ Yes ☐ No

If yes, how many meetings per week: _____

If no, what is your plan to assist member in connecting to a sober support system in the community?

_____

_____

CLINICAL INFORMATION: (Please complete the following)

6. Does member have a sponsor? ☐ Yes ☐ No If yes, how many contacts per week? _____

7. Is member working on the 12 steps? ☐ Yes ☐ No If yes, what step is member on? _____

8. Does member have a Sober Support Phone Tree? ☐ Yes ☐ No

If yes, how many #'s collected? _____ How often used? _____

9. What is member's current assignment?

_____

_____

10. Is member able to give feedback w/o being hurtful?

_____

_____

11. Is member able to take feedback w/o taking offense?

_____

_____

12. Any Significant insight/connections made? Any Behavior Changes? ☐ Yes ☐ No If yes, please explain:

_____

_____

13. Has member learned coping skills? What skills? Please explain:

_____

_____

ASAM DIMENSIONS (please explain all medium and high ratings)

1. Alcohol Intox. And/or Withdrawl Potential • Any risk of severe withdrawl/seizures? • Any current signs of withdrawl?	**LOW**	**MED**	**HIGH**
EXPLAIN			

2. Biomedical Conditions & Complications • Any current physical illness (besides withdrawl) that may impact course of treatment? • Is member pregnant? ☐ Yes ☐ No	**LOW**	**MED**	**HIGH**
EXPLAIN			

ASAM DIMENSIONS (please explain all medium and high ratings)

3. Emotional/Behavioral or Cognitive Conditions & Complications • Any psych. illness or psychological, behavioral, or emotional problems that may impact the course of the treatment?	LOW	MED	HIGH
EXPLAIN			

4. Readiness to Change (Treatment Acceptance/Resistance) • Is the member objecting/resistant to treatment? • What is the member's readiness to change?	LOW	MED	HIGH
EXPLAIN			

ASAM DIMENSIONS (please explain all medium and high ratings)

5. Relapse (Continued Use Potential) • Is the member in immediate danger of continued severe distress, and drinking/drug behavior? • Does the member have any understanding of, or skills in which to cope with his/her addiction problems in order to prevent relapse/continued use?	LOW	MED	HIGH
EXPLAIN			

6. Recovery Environment • Are there family members, significant others, living situations, or school/work situations that pose a threat to TX engagement and success? • Does the member have supportive friendships, financial, educational, or vocational resources that will increase the likelihood of successful TX?	LOW	MED	HIGH
EXPLAIN			

Provider Signature: _____ **Date:** _____

LEVEL OF CARE DETERMINATION: ** FOR AC Use Only

LOC	DATE OF REQUEST	SESSIONS	START DATE	END DATE	TX PLAN DUE DATE	TC DUE DATE	AUTH #	CRITERIA USED

APPROVED: ☐ YES ☐ NO ☐ PARTIAL DATE OF DECISION: Reviewers signature _____ MD signature: _____